S. Hrg. 102-701

HOME HEALTH AGENCY FRAUD

HEARING

BEFORE THE

COMMITTEE ON THE BUDGET
UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

SECOND SESSION

NASHVILLE, TN

MAY 16, 1992

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HOME HEALTH AGENCY FRAUD

SATURDAY, MAY 16, 1992

U.S. SENATE,
COMMITTEE ON THE BUDGET,
Nashville, TN.

The committee met, pursuant to notice, at 10 a.m., at Legislative Plaza, room 16, Nashville, TN, Hon. Jim Sasser (chairman of the committee) presiding.

Present: Senator Sasser.

Staff present: John S. Wagster, senior analyst; and James Pratt, director of communications

OPENING STATEMENT OF CHAIRMAN SASSER

Chairman SASSER. I hereby call this field hearing of the Budget Committee of the United States Senate to order.

I want to say good morning to all of you. Thank you very much for coming today.

This hearing that I have called is an investigation into inefficiency and waste in Federal reimbursement for home health care services.

Now as many of you know, this is not the committee's first such inquiry into health care inefficiency and fraud. As a matter of fact, over the last year, the Senate Budget Committee has held five hearings into waste and abuse in the medicare system, dealing primarily with reimbursement for durable medical equipment and supplies.

We held one field hearing here in Nashville, TN, and another in, of all places, North Dakota, and three hearings of the full committee in Washington, DC.

I am pleased to report that with the help of the Office of the Inspector General of the Department of Health and Human Services, with the cooperation of many individuals in the durable medical equipment business, and with the help of some courageous individuals who came forward and testified and gave us information in public, we were able to formulate a structure which will save the Federal Government millions of dollars in the field of durable medical equipment.

As a matter of fact, according to figures of the Office of Management and Budget of the Administration, the regulations and legislation which we have put into effect will save the Federal Government $200 million a year over the next 5 years. Now that is a $1 billion savings just in the relatively small portion of the medicare system that deals with durable medical equipment.

As we turn our attention to investigation into home health reimbursement, I am not suggesting that we are going to turn up the same type of abuse that we found in the durable medical equipment field. I certainly hope that we do not. Yet I do feel that we have a duty to proceed because I see that trends in the reimbursement for home health care are strikingly similar to the problems that led to my investigation of medical equipment abuse.

Medicare patients in general and homebound patients in particular are a very vulnerable section of our population, and because of that increased vulnerability that often comes with age or sickness, we have a special duty, I think, to protect these elderly patients and also a special duty to protect the Medicare Program from waste and abuse as it tries to minister to their needs.

I want to make a few things very clear here at the outset. Home health care services are among the most valuable that medicare and medicaid can provide. Every dollar that is effectively spent for home health care is money saved, that would be spent in a more expensive alternative of a hospital or a nursing home. Having a health care nurse or a home therapist visit a patient on a regular basis is really much cheaper than admitting that patient into a hospital.

So my support for home health care is solid and it is unwavering, make no mistake about that. I want to emphasize that the great majority of those who provide home health care are good, ethical, honorable business people.

But as we often find in a situation where there is a great pool of money, it always has a tendency to attract a few bad apples, and there are, I think, some home health care providers who are giving the industry a bad name. Today we are taking the first step towards putting some of these unscrupulous people out of business.

The potential problems in home health care reimbursement were called to my attention by a wide range of unsolicited complaints that came into our offices across Tennessee. We maintain five field offices in this State, and people were bringing their complaints and allegations directly to us. They started bringing them to our offices and to me really as a result of our investigation into the durable medical equipment abuses that we started early.

Now many of you know that home health care reimbursements are made through the Part A portion of medicare, but there are also some that are made through the Part B portion which deals with physicians. Our investigation deals with both.

Where have we learned specifically about abuses, or allegations of abuses would be more accurate to say? We have been contacted by physicians, by doctors, who felt that some home health care providers are ordering more tests and providing more visits than the doctor thought was medically necessary.

We have also received complaints from the beneficiaries of home health care themselves or from the family members of beneficiaries who, after the fact, have learned that medicare has been billed for literally thousands of dollars for services that either the beneficiary or the next of kin of the beneficiary did not think was desirable or had not even requested. Many times they did not know about the extent of this treatment until they received the form,

which is an explanation of medicare benefits which detailed the charges.

Also, and perhaps most convincingly, we have been contacted by home health care nurses who tell us about routine pressure from their employers to make visits to homebound beneficiaries, elderly, ill people, that these nurses don't feel are necessary.

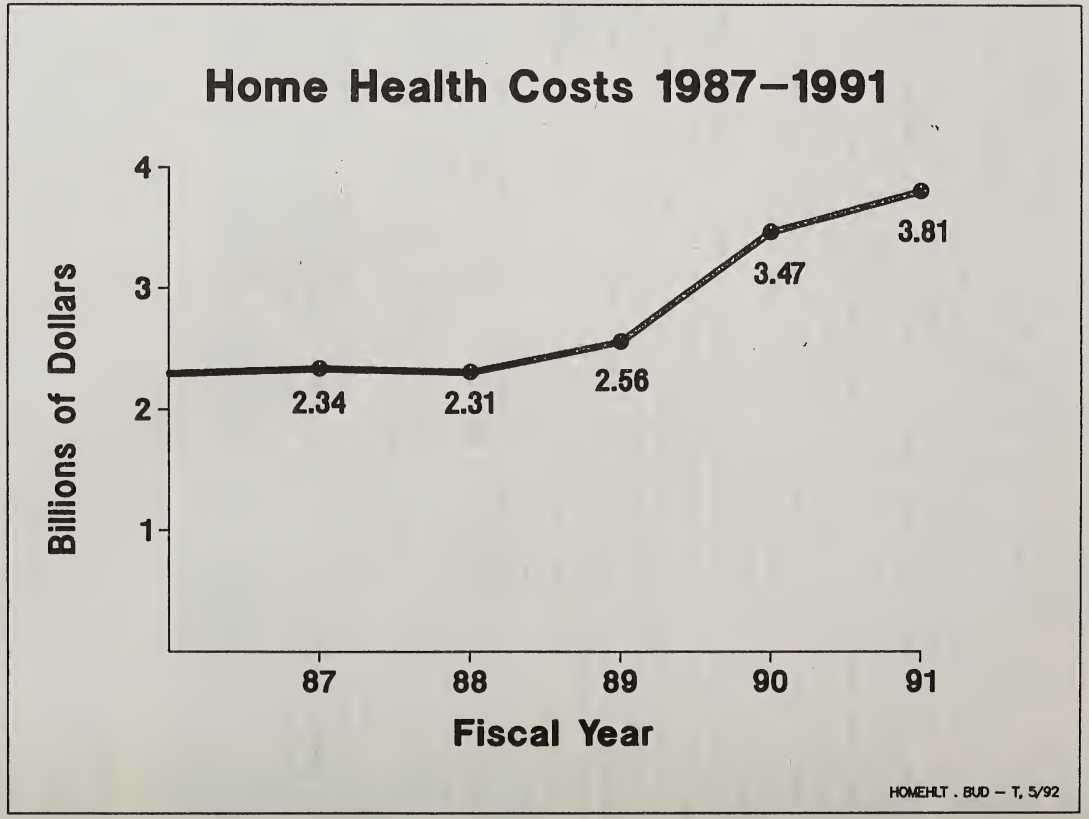
We have also been told by some of these same home health care nurses that they have been told in advance about inspections that will be made by those who have the responsibility for seeing that the home health care system works efficiently. They have been told in advance of these inspections, and they in turn have called the patients at home to make sure the patients will be home and to make sure the patients say the right thing to the inspectors so that the home health care visits can continue.

Perhaps the most disturbing thing about these abuses and others is that many of them appear to be routine practices by offending providers. They are not just unrelated and scattered occurrences.

As we have learned from our past investigations, where the possibility exists to exploit the Medicare program for profit, and I mean potentially very large profits, there are always going to be, unhappily, individuals seeking to take advantage of that possibility.

Now another thing that attracted the committee's attention to the field of home health care and the fact that it could be a potential problem is the rapid increase in home health care reimbursements. Expenditures by the medicare system for home health care have increased over 400 percent since 1981, from $914 million in 1981 to over $3.8 billion in 1991.

Our chart here indicates that even since the most recent changes in the home health care law in 1987, home health care costs have increased by 62 percent. For example, the chart begins here in 1987, showing home health care costs at $2.34 billion. You notice the sharp increase in 1989, beginning to climb to $3.81 billion. That's $3,810,000,000 by 1991.


Home Health Costs 1987–1991
Billions of Dollars
4
3
2
1
2.34
2.31
2.56
3.47
3.81
87
88
89
90
91
Fiscal Year
HOMEHLT . BUD – T, 5/92

We find that home health care services are increasing faster than the growth in medicare overall. Since 1987, home health care expenditures have grown 33 percent faster than the overall medicare budget. Over that same period of time, the number of medicare beneficiaries has increased by only 8 percent, so that is something that attracts our attention.

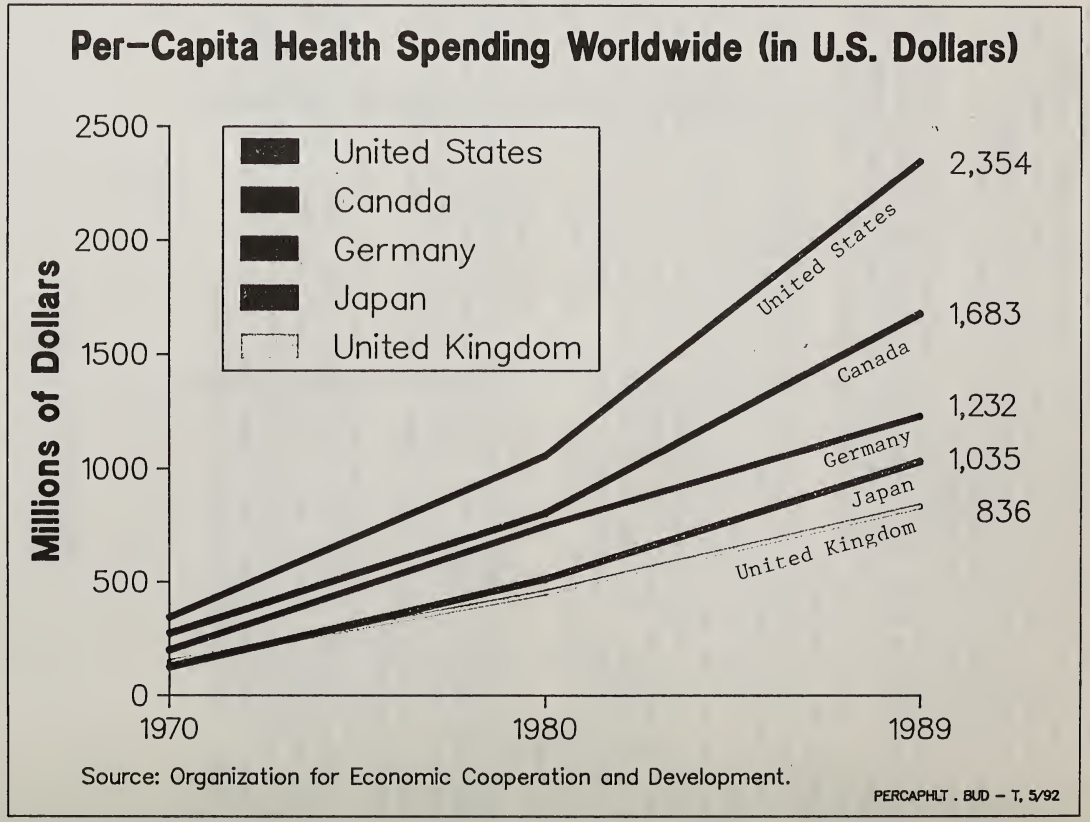
If we just look at it in the abstract, we want to know, what is the explanation for this very substantial increase in home health care costs? Why is it going up one-third faster than medicare costs generally, particularly when medicare beneficiaries have only increased by 8 percent?

Now I don't mean to imply that all these increases are the result of abuse or certainly the result of fraudulent activity, because they are not. There have been some changes in the law, which I expect will be pointed out this morning, that expand the home health care benefit, and I support these changes. They enlarge the home health care benefit and provide for increased services. There has also been a court decision that has resulted in increased cost to the program.

But I strongly suspect that at least a substantial percentage of the home health care increases come as a result of waste and abuse.

Now why are we so concerned about this particular facet of the medicare system? Why are we so concerned about the increase in durable medical equipment cost? It is because the overall cost of health care expenditures in the United States are much larger and going up much faster than those of any other industrialized country in the world.

What this chart indicates is that we in the United States are spending $2,354 per person, for every man, woman, and child in this country for health care, and you note the red line here of the U.S. expenditures is going up much faster than the other industrialized countries. We have chosen as examples Canada, Germany, Japan, the United Kingdom or Great Britain.


Per–Capita Health Spending Worldwide (in U.S. Dollars)
Millions of Dollars
2500
2000
1500
1000
500
0
1970
1980
1989
United States
Canada
Germany
Japan
United Kingdom
2,354
1,683
1,232
1,035
836
Source: Organization for Economic Cooperation and Development.
PERCAPHLT . BUD – T, 5/92

Our closest competitor is Canada, and their health care costs factor out at $1,683 per person in that country. They are followed by Germany, which is $1,232, followed by Japan where they spend just a few dollars over $1,000 per person for health care. And then of course we have the United Kingdom, where it is only $836 per person.

We spend about 2½ times per capita, for example, more than they do in Great Britain for health care. Bear in mind that we have over 35 million Americans who have no health insurance whatsoever, and we have many Americans who get what some consider to be substandard health care through the medicaid system, whereas in Canada, Germany, Japan, and the United Kingdom every citizen of that country is afforded essentially the same caliber of medical care.

Now we do know that the finest medical care in the world is right here in the United States. We have one of the most advanced medical care or health care systems in the world, but the problem is that it is becoming less and less affordable. This high quality health care is becoming available to fewer and fewer Americans every year as the cost continues to explode.

So as we look into the medicare system and other facets of the health care system that I intend to investigate, as we isolate the reasons for these increased costs and as we can put in place, if possible, fixes to save some of this money, then it means that every dollar that we save would be funds that we could invest in making the medicare system more effective. We could also invest the funds in other areas of Federal responsibility that badly need them.

Today's hearing is part of my ongoing effort to ensure that the country's limited financial resources are spent as effectively as possible.

Today we are going to hear first from Mr. James Cottos, the Regional Inspector General for Investigations from the Atlanta Office. Mr. Cottos will tell us about some of the problems his office is encountering with the home health program.

Next, we will hear from Ms. Gayla Sasser, who I hasten to add is of no relation although I would be proud to claim her. She is the executive director of the Tennessee Association for Home Care. She asked me when I got here this morning if I was going to explain to people we weren't related. I think maybe she is not that proud to claim me, but in any case there is no relation.

They will be joining us this morning, and we will begin first with you, Mr. Cottos.

STATEMENT OF JAMES M. COTTOS, REGIONAL INSPECTOR GENERAL FOR INVESTIGATIONS, ATLANTA FIELD OFFICE, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Cottos. Thank you, Senator. I am very pleased to be here in response to your request to testify on our activities designed to identify and curb fraud within the Medicare program.

The home health care fraud is an area which squanders scarce resources, impugns the integrity of the program, and inhibits the delivery of quality health care.

As previously agreed, I have limited my testimony to cases which are not under grand jury protection or which are now pending in District Courts.

Medicare pays for home health visits only if all four of the following conditions are met. Number one, the patient needs care which includes intermittent skilled nursing care, physical therapy or speech therapy; and two, the patient is confined to their home, is homebound; and number three, the patient's physician determines the need for home health care and prepares a specific plan of care; and fourth, the home health agency providing the service participates in medicare.

Now to become medicare-certified, a home health agency must one, directly provide skilled nursing and at least one other service, and two, meet medicare's conditions of participation. There are regulations which set forth the standards for such things as staff qualifications, medical record keeping, and quality assurance procedures.

We have had successful work in the area of investigations of home health agencies. Since 1986, we have successfully prosecuted 22 home health agencies and their employees for medicare fraud, and just in the last 2 years, we have excluded 16 home health agencies, owners, or employees from participating in the program.

We have identified several categories of fraud in the HHA operations, which we believe occur throughout the United States. Those are cost report fraud, excessive services or services not rendered, use of unlicensed or untrained staff, falsify of plans of care and forged doctors' signatures, kickbacks, entrepreneurship, and intermediary hopping.

I would like to just speak briefly on each. The cost report fraud concerns attempts to write off items not used in providing care to beneficiaries, and this represents the largest single area of fraudulent activity we have identified, and this is any personal expenses regarding vacations, purchasing of automobiles, home furnishings, jewelry, et cetera.

I want to make a note that many of our cases have been initiated following referrals of suspicious findings from the intermediary audit staff, particularly here in Tennessee. In many instances, we have used these auditors to assist us in certain aspects of the investigation.

Chairman SASSER. Excuse me. Can the audience hear Mr. Cottos? Good. Thank you.

Mr. COTTOS. Number two, the second area is claims approved or excessive services. An HHA should provide only those services which the physician orders. However we have seen instances where the HHA directed nurses and aides to make unnecessary visits or to falsify documentation in an effort to make it appear that necessary visits were made.

Number three, use of unlicensed or untrained personnel—the physician's role in authorizing the health care is critical. Although the home health agency may evaluate the patient to determine whether requirements for medicare coverage are met, it is up to the physician to certify the medical need for home health care and to establish a plan of care.

Fourthly, falsified plans, once a certification and plan of care have been obtained, the HHA deals directly with the intermediary in submitting claims for reimbursement. If the physician refuses to sign a plan of care, we found that some HHAs simply forge a signature to the document and submit it without his knowledge.

The fifth area is kickbacks. We have several investigations currently in progress regarding hospital discharge planners who are requesting and accepting kickbacks to refer patients to certain home health agencies. We also have cases involving physicians who are being paid kickbacks to send patients to particular home health agencies.

Entrepreneurship—we have recently seen a proliferation of business arrangements which are intended to enhance the investment potential of health care providers by appealing to investors who are in a position to direct a stream of referrals to those businesses. Hospitals, physicians, and other potential resources have become involved in the HHA field as owners or investors.

Intermediary hopping—claims for home health services are submitted to the regional medicare intermediary serving the geographic area in which the HHA providing the service is located. The HHA has the right, however, to elect another intermediary under circumstances which would be more efficient for claims processing. This change must be approved by HCFA. However, by checking around to see which intermediaries pay the most for home health care, some HHAs have moved their home office operations to a location served by that intermediary in order to take advantage of these reimbursement policies.

I would like to address for a minute the quality of home health care. Congress included provisions in the Omnibus Budget Reconciliation Act of 1987 to strengthen the quality of home health services. Among those provisions were that required surveyors to measure the impact of home health care on patient health, to evaluate the quality of that care, required surveys to visit patients' homes to obtain information on the quality of care, gave HCFA a range of sanctions to impose on home health agencies that did not comply with home health standards, required agents to be surveyed at least every 15 months, and required the Secretary to develop training standards for medical equipment supply or personnel.

Chairman SASSER. Mr. Cottos, let me just interrupt there. These new Congressional requirements went in, you said, in 1987?

Mr. COTTOS. 1987, yes sir.

Chairman SASSER. Yet we see here that there is no increase in home health costs between 1987 and 1989, and not too large between 1987 and 1989, although it begins the uptick and then really starts taking off there in 1990 and 1991.

Do you have any——

Mr. COTTOS. I think there was an adjustment period when these regulations went into effect where everyone was very concerned about the new regulations, but then the realized enforcement was a little bit lax, and I think that is when, at least in our position, that is when the costs started going up.

Chairman SASSER. In other words, it is your position that when the providers realized that the enforcement was lax, after the expanded care went into effect——

Mr. COTTOS. That is correct.

Chairman SASSER [continuing]. That that is when the costs started going up substantially?

Mr. COTTOS. Yes Senator, that is exactly correct.

Chairman SASSER. All right, thank you.

Mr. COTTOS. The Inspector General did a report on home health aide services for medicare patients in 1988, which raised questions about whether the State surveys could be relied on to ensure that medicare patients were receiving quality home health care.

The report shows that half the services ordered were not performed. It also showed poor supervision of aides caused inadequate care and that aides under contract to agencies did not perform the majority of skilled care tasks that were assigned to them. This lack of care deprives the patient of full home care, resulting in a possible decreased potential for rehabilitation or increased chance of readmittance to a hospital.

In summary, Senator, the interests of this committee in examining issues related to the Medicare Program is well placed. Since medicare expenditures are continuing their unprecedented growth, we must determine how we might best protect the program from fraud and abuse. We should also consider how we can accomplish this goal while ensuring maximum cost effectiveness.

Home health care should be one of the nation's most cost-effective services, because it offers an alternative to the high cost of inpatient nursing home and hospital care. However, the magnitude of recent increases in home care expenditures have led us to conclude that this type of non-institutional care may some day be just as expensive as hospitalization.

Additionally, unresolved issues——

Chairman SASSER. Mr. Cottos, can I interrupt you there?

Mr. COTTOS. Yes sir.

Chairman SASSER. Are you saying that because of the curve of increase in home health care that your agency now feels that if it continues its present rate of increase, it one day may be as expensive as hospital or nursing home care?

Mr. COTTOS. With the rate, as you pointed out in your testimony, Senator, in your statement, with the rate that it is going up, yes, we believe if it continues on that path it will be just as expensive as hospital care.

Chairman SASSER. Thank you.

Mr. COTTOS. Additionally, unresolved issues relating to ensuring quality of care threaten the medicare beneficiary with receiving less than adequate care for that increased expense.

This concludes my prepared testimony. I will be happy to answer any questions, Senator.

Chairman SASSER. Well, thank you very much, Mr. Cottos.

[The prepared statement of Mr. Cottos follows:]

STATEMENT BY

JAMES M. COTTOS
REGIONAL INSPECTOR GENERAL FOR INVESTIGATIONS
ATLANTA FIELD OFFICE
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE
SENATE BUDGET COMMITTEE

ON

HOME HEALTH AGENCY FRAUD

MAY 16, 1992

GOOD MORNING. I AM JAMES COTTOS, REGIONAL INSPECTOR GENERAL FOR INVESTIGATIONS OF THE ATLANTA FIELD OFFICE, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES. I AM PLEASED TO BE HERE IN RESPONSE TO YOUR REQUEST TO TESTIFY ON OUR ACTIVITIES DESIGNED TO IDENTIFY AND CURB FRAUD WITHIN THE MEDICARE PROGRAM. I'D LIKE TO FOCUS THE COMMITTEE'S ATTENTION ON AN AREA OF CONCERN TO OUR OFFICE: HOME HEALTH CARE FRAUD WHICH SQUANDERS SCARCE RESOURCES, IMPUGNS THE INTEGRITY OF THE PROGRAM AND INHIBITS THE DELIVERY OF QUALITY HEALTH CARE. AS PREVIOUSLY AGREED, I HAVE LIMITED MY TESTIMONY TO THOSE CASES WHICH ARE NOT UNDER GRAND JURY PROTECTION OR WHICH ARE PENDING IN DISTRICT COURTS.

BACKGROUND

MEDICARE, AUTHORIZED BY TITLE XVIII OF THE SOCIAL SECURITY ACT, HELPS PAY HEALTH CARE COSTS FOR ABOUT 35 MILLION AGED AND DISABLED PEOPLE. MEDICARE CONSISTS OF TWO PARTS -- HOSPITAL INSURANCE (PART A) AND SUPPLEMENTAL MEDICAL INSURANCE (PART B). PART A IS PRIMARILY FINANCED BY A PAYROLL TAX FROM EMPLOYERS, EMPLOYEES, AND THE SELF-EMPLOYED. PART B IS A VOLUNTARY PROGRAM FINANCED BY GENERAL REVENUES AND PREMIUMS COLLECTED FROM PARTICIPATING BENEFICIARIES.

THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) ADMINISTERS MEDICARE. THE HCFA CONTRACTS FOR CLAIMS PROCESSING AND PAYMENT WITH VARIOUS BLUE CROSS AND BLUE SHIELD PLANS AND OTHER

COMMERCIAL INSURANCE COMPANIES. IN PART A THESE CONTRACTORS ARE KNOWN AS INTERMEDIARIES. IN PART B THEY ARE KNOWN AS CARRIERS.

MEDICARE USES 9 REGIONAL INTERMEDIARIES TO PAY CLAIMS FROM HOME HEALTH AGENCIES (HHAs). INTERMEDIARIES (1) RECEIVE CLAIMS FOR SERVICES, AND MAKE PAYMENTS FOR COVERED SERVICES PROVIDED BY HHAs, (2) AUDIT ANNUAL COST REPORTS TO DETERMINE THE ALLOWABLE COST INCURRED BY HHAs AND TO RECONCILE PAYMENTS MADE WITH PAYMENTS DUE AND (3) HELP IN ESTABLISHING AND APPLYING SAFEGUARDS AGAINST THE UNNECESSARY USE OF SERVICES.

THE OFFICE OF INSPECTOR GENERAL (OIG) HAS A STATUTORY RESPONSIBILITY TO PROTECT THE INTEGRITY OF ALL DEPARTMENTAL PROGRAMS INCLUDING MEDICARE. THROUGH OUR COMPREHENSIVE PROGRAM OF INVESTIGATIONS, AUDITS, PROGRAM EVALUATIONS, AND INSPECTIONS, WE FREQUENTLY IDENTIFY WEAKNESSES THAT MAY ADVERSELY IMPACT ON THIS PROGRAM, MAKING IT SUSCEPTIBLE TO FRAUD. FRAUD MUST BE DETECTED AND PROMPTLY DEALT WITH TO ENSURE THAT OUR LIMITED RESOURCES ARE EFFECTIVELY USED FOR THE PURPOSE THEY WERE INTENDED AND, JUST AS IMPORTANTLY, TO PROTECT THE QUALITY OF CARE PROVIDED TO BENEFICIARIES.

HOME HEALTH AGENCIES

CURRENTLY, MEDICARE PAYS FOR THREE PRIMARY TYPES OF HOME HEALTH SERVICES TO BENEFICIARIES -- PART-TIME OR INTERMITTENT SKILLED

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NURSING SERVICES, PHYSICAL THERAPY, AND SPEECH THERAPY. IF ONE OR MORE OF THOSE THREE ARE NEEDED, OCCUPATIONAL THERAPY, MEDICAL SOCIAL SERVICES, MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT AND PART-TIME OR INTERMITTENT HOME HEALTH AIDE SERVICES MAY ALSO BE COVERED.

MEDICARE PAYS FOR HOME HEALTH VISITS ONLY IF **ALL FOUR** OF THE FOLLOWING CONDITIONS ARE MET:

1) THE PATIENT NEEDS CARE WHICH INCLUDES INTERMITTENT SKILLED NURSING CARE, PHYSICAL THERAPY, OR SPEECH THERAPY, **AND**

2) THE PATIENT IS **CONFINED TO THEIR HOME (HOMEBOUND)**, **AND**

3) THE PATIENT'S PHYSICIAN DETERMINES THE NEED FOR THE HOME HEALTH CARE AND PREPARES A SPECIFIC PLAN OF CARE, **AND,**

4) THE HHA PROVIDING THE SERVICES PARTICIPATES IN MEDICARE.

TO PARTICIPATE IN MEDICARE, AN HHA MUST MEET REQUIREMENTS SPECIFIED IN THE SOCIAL SECURITY ACT AND IMPLEMENTING REGULATIONS. THE ACT DEFINES AN HHA AS A PUBLIC AGENCY OR PRIVATE ORGANIZATION PRIMARILY ENGAGED IN PROVIDING SKILLED NURSING AND OTHER THERAPEUTIC SERVICES. TO BECOME MEDICARE CERTIFIED, AN HHA MUST (1) DIRECTLY PROVIDE SKILLED NURSING AND AT LEAST ONE OTHER SERVICE AND (2) MEET MEDICARE'S CONDITIONS OF PARTICIPATION. THE REGULATIONS RELATED TO THE CONDITIONS OF PARTICIPATION SET FORTH STANDARDS FOR SUCH THINGS AS STAFF QUALIFICATIONS, MEDICAL RECORD KEEPING, AND QUALITY ASSURANCE PROCEDURES. HHAs ARE PERIODICALLY REVIEWED BY STATE INSPECTION

AGENCIES TO ASSURE THEY ARE IN COMPLIANCE WITH THESE STANDARDS.

FROM 1979 TO 1990, THE NUMBER OF HHAs PROVIDING MEDICARE SERVICES NEARLY DOUBLED, FROM ABOUT 2,800 TO 5,700. AT THE SAME TIME, MEDICARE SPENDING FOR HOME HEALTH CARE INCREASED DRAMATICALLY, FROM $592 MILLION TO $3.5 BILLION, MAKING IT ONE OF THE FASTEST GROWING COMPONENTS OF MEDICARE COSTS. A VARIETY OF FACTORS ACCOUNT FOR THESE INCREASES, INCLUDING AN AGING POPULATION, CHANGES IN MEDICARE PAYMENT POLICIES THAT ENCOURAGE EARLIER DISCHARGE FROM HOSPITALS, AND EXPANDED HOME HEALTH BENEFITS. ADDITIONALLY, THERE HAVE BEEN COURT DECISIONS AND STATUTORY CHANGES WHICH HAVE CONTRIBUTED TO THE GROWTH OF EXPENDITURES IN THIS AREA.

INVESTIGATIONS OF HOME HEALTH AGENCY FRAUD

YOUR INQUIRIES LAST YEAR INTO MEDICARE FRAUD IN THE AREA OF DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES WERE VERY VALUABLE, AND HAVE HELPED TO BRING ABOUT SOME VERY POSITIVE CHANGES IN THAT AREA OF THE MEDICARE PROGRAM. FOR EXAMPLE, HCFA HAS PROPOSED NEW REGULATIONS WHICH, WHEN IMPLEMENTED, WILL PROHIBIT THE PRACTICE KNOWN AS "CARRIER SHOPPING". THE REGULATION REVISES THE MANNER A DETERMINATION OF WHICH CARRIER HAS JURISDICTION FOR PROCESSING CLAIMS IS MADE. THE PLACE OF RESIDENCE OF THE BENEFICIARY WILL DETERMINE WHICH CARRIER SHOULD HAVE JURISDICTION, RATHER THAN USING THE PLACE WHERE AN ORDER FOR AN ITEM OR SERVICE IS RECIVED.

THESE NEW REGULATIONS WILL ALSO CONSOLIDATE THE CLAIMS PROCESSING ACTIVITIES IN THE DME AREA INTO FOUR REGIONAL CARRIERS, THUS MAKING IT EASIER TO IMPLEMENT AND ENFORCE PROGRAM SAFEGUARDS, AS WELL AS INCREASING THE EFFICIENCY OF THE CLAIMS PROCESS.

BECAUSE HHAs PROVIDE CARE IN THE PATIENT'S HOME, WITH LIMITED SUPERVISION, THERE IS A VULNERABILITY TO FRAUD SCHEMES SIMILAR TO THOSE FOUND IN THE DME ARENA. ADDITIONALLY, THERE ARE OTHER SIMILARITIES IN THE WAY THIS COVERAGE AREA IS MANAGED THAT INCREASE THIS VULNERABILITY.

WHILE MOST HHAs ARE CERTAINLY LEGITIMATE OPERATIONS, SOME ARE QUESTIONABLE, AND A FEW ARE OUTRIGHT DISHONEST. SINCE 1986, WE HAVE SUCCESSFULLY PROSECUTED 22 HHAs AND THEIR EMPLOYEES FOR MEDICARE FRAUD. IN THE LAST 2 YEARS, WE HAVE EXCLUDED 16 HHAs, OWNERS OR EMPLOYEES FROM PARTICIPATING IN MEDICARE.

I WOULD LIKE TO BRING TO THIS COMMITTEE'S ATTENTION SEVERAL CATEGORIES OF FRAUD WHICH WE HAVE SEEN IN HHA OPERATIONS AND WHICH WE BELIEVE OCCUR THROUGHOUT THE UNITED STATES. THESE INCLUDE:

- COST REPORT FRAUD;
- EXCESSIVE SERVICES OR SERVICES NOT RENDERED;
- USE OF UNLICENSED OR UNTRAINED STAFF;
- FALSIFIED PLANS OF CARE AND FORGED PHYSICIAN'S SIGNATURES;

- KICKBACKS;
- ENTREPRENEURSHIP.
- INTERMEDIARY HOPPING; AND

LET ME BRIEFLY DISCUSS EACH CATEGORY.

1. COST REPORT FRAUD

THE FIRST TYPE OF SCHEME INVOLVES FALSIFYING HHA ANNUAL COST REPORTS. THESE REPORTS, WHICH ARE SUBJECT TO AUDIT BY THE INTERMEDIARIES, ARE THE BASIS FOR DETERMINING THE ALLOWABLE COSTS OF FURNISHING SERVICES AND DETERMINING MEDICARE'S SHARE OF THOSE COSTS.

THERE IS A VULNERABILITY TO FRAUD IN THIS PROCESS. ATTEMPTS TO WRITE OFF ITEMS NOT USED IN PROVIDING CARE TO BENEFICIARIES REPRESENTS THE LARGEST SINGLE AREA OF FRAUDULENT ACTIVITY WE HAVE IDENTIFIED.

MANY OF OUR CASES HAVE BEEN INITIATED FOLLOWING REFERRAL OF SUSPICIOUS FINDINGS FROM THE INTERMEDIARY'S AUDIT STAFF. IN SOME INSTANCES, WE HAVE USED THEIR AUDITORS TO ASSIST US IN CERTAIN ASPECTS OF OUR INVESTIGATIONS. LET ME PROVIDE YOU WITH TWO EXAMPLES OF CASES THAT WERE REFERRED TO OUR OFFICE BY AN INTERMEDIARY:

- AN AUDIT OF A TENNESSEE HHA DISCLOSED THE INCLUSION OF MANY INAPPROPRIATE EXPENSES IN THEIR COST REPORTS. AMONG THESE WERE AMERICAN EXPRESS CHARGES FOR VACATIONS FOR THE OWNER'S FAMILY, INCLUDING AIRLINE TICKETS, CAR RENTALS, HOTEL

LODGING, AND FLOWERS; A PIANO FOR THE OWNER'S HOME; AND A VARIETY OF HOME FURNISHINGS SUCH AS FURNITURE, CARPETING AND LINENS. OUR INVESTIGATION REVEALED THAT THE OWNER OF THE HHA GAVE THE BOOKKEEPER INSTRUCTIONS ON HOW TO DISGUISE THE NATURE OF THESE PURCHASES. THE OWNER PLED GUILTY TO 2 COUNTS OF MAKING FALSE STATEMENTS TO THE GOVERNMENT, AND WAS SENTENCED TO 5 YEARS OF PROBATION, ORDERED TO MAKE RESTITUTION OF $31,000, AND PERFORM 150 HOURS OF COMMUNITY SERVICE.

- AN AUDIT OF ANOTHER TENNESSEE HHA DISCLOSED THE FILING OF FALSE COST REPORTS FOR 3 YEARS. OVER $55,000 IN INAPPROPRIATE EXPENSES WAS CITED, INCLUDING FURNITURE, CARPETING, CLOTHING, AND FOOD FOR PERSONAL USE. INFLATED AND FALSIFIED MILEAGE WAS ALSO INCLUDED IN THE REPORTS. IN ONE INSTANCE, ONE OF THE OWNERS CLAIMED MILEAGE FOR TWO DIFFERENT CARS GOING IN TWO DIFFERENT DIRECTIONS ON THE SAME DAY. THE OWNERS PLED GUILTY TO MAKING FALSE STATEMENTS IN FILING MEDICARE COST REPORTS, AND WERE EACH SENTENCED TO 3 YEARS PROBATION, FINED $3,050 AND ORDERED TO PERFORM 200 HOURS OF COMMUNITY SERVICE.

2. UNAPPROVED OR EXCESSIVE SERVICES

THE SECOND SCHEME INVOLVES EXCESSIVE SERVICES OR SERVICES NOT RENDERED. AS DISCUSSED PREVIOUSLY, HOME CARE SERVICES MUST BE (1) ORDERED IN A "PLAN OF CARE" PREPARED AND PERIODICALLY REVIEWED BY A PHYSICIAN AND (2) FURNISHED BY A PARTICIPATING HHA, EITHER DIRECTLY OR THROUGH ARRANGEMENTS WITH OTHERS. AN HHA SHOULD PROVIDE ONLY THOSE SERVICES WHICH THE PHYSICIAN ORDERS. HOWEVER, WE HAVE SEEN INSTANCES IN WHICH THE HHA DIRECTED NURSES AND AIDES TO MAKE UNNECCESARY VISITS, OR TO FALSIFY DOCUMENTATION IN AN EFFORT TO MAKE IT APPEAR THAT NECESSARY VISITS WERE MADE.

- IN ONE CASE, A FLORIDA HHA BILLED FOR OVER $350,000 IN HOME CARE SERVICES THAT WERE NEVER PROVIDED. THE INVESTIGATION REVEALED THAT THE BENEFICIARIES NEVER RECEIVED THE CARE, OR WERE IN NURSING HOMES WHERE SUCH HOME HEALTH CARE IS NOT COVERED. IN ONE INSTANCE, THE ALLEGED RECIPIENT OF CARE HAD ALREADY DIED. THE HHA WAS FINED OVER $1,000, AND ORDERED TO PAY $225 IN COURT COSTS. THE OWNER OF THE HHA WAS ALSO

SENTENCED TO 2 YEARS OF COMMUNITY SERVICE, FINED $40,000 AND ORDERED TO PAY RESTITUTION OF $300,000. BOTH THE HHA AND ITS OWNER WERE EXCLUDED FROM PARTICIPATION IN THE MEDICARE AND STATE HEALTH CARE (MEDICAID) PROGRAMS FOR 10 YEARS.

3. USE OF UNLICENSED OR UNTRAINED PERSONNEL

SOMETIMES, SERVICES MAY BE PROVIDED BY UNQUALIFIED INDIVIDUALS. WE HAVE BEEN CONCERNED WITH THIS FOR SOME TIME. WHILE CONGRESS HAS ADDRESSED IT PREVIOUSLY, ADDITIONAL CORRECTIVE ACTION IS REQUIRED. THE SCHEME OF USING UNLICENSED OR UNTRAINED PERSONNEL IS GENERALLY PART OF A LARGER PATTERN OF FRAUD.

- IN A CASE INVOLVING PROFESSIONAL CARE INC. (PCI), ONCE THE NATION'S LARGEST PROVIDER OF HOME HEALTH SERVICES, THERE WERE ALLEGATIONS OF TREATMENT BY UNTRAINED AND UNQUALIFIED AIDES. OUR INVESTIGATION REVEALED THAT CREDENTIALS OF PERSONAL AND HOME HEALTH CARE AIDES WERE FALSIFIED. EXECUTIVE OFFICERS OF PCI PLED GUILTY TO FALSIFYING PERSONNEL FILES AND GRAND LARCENY, AND AGREED TO PAY $4.75 MILLION IN CIVIL LIABILITIES. IN ADDITION, PCI WAS EXCLUDED FOR 15 YEARS FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE (MEDICAID) PROGRAMS.

4. FALSIFIED PLANS OF CARE AND FORGED PHYSICIAN'S SIGNATURES

THE PHYSICIAN'S ROLE IN AUTHORIZING HOME HEALTH CARE IS CRITICAL. ALTHOUGH THE HHA MAY EVALUATE THE PATIENT TO DETERMINE WHETHER THE REQUIREMENTS FOR MEDICARE COVERAGE ARE MET, IT IS UP TO A PHYSICIAN TO CERTIFY (AND PERIODICALLY RECERTIFY) THE MEDICAL NEED FOR HOME HEALTH CARE AND TO ESTABLISH A PLAN OF CARE. IT IS IMPORTANT TO NOTE, HOWEVER, THAT THE PHYSICIAN WHO PERFORMS THESE TASKS IS NOT REQUIRED TO ACTUALLY SEE THE PATIENT.

ONCE THE CERTIFICATION AND PLAN OF CARE HAVE BEEN OBTAINED, THE HHA DEALS DIRECTLY WITH THE INTERMEDIARY IN SUBMITTING CLAIMS FOR REIMBURSEMENT. WE HAVE FOUND THAT SOME UNSCRUPULOUS HHAs WILL SUBMIT CLAIMS FOR SERVICES WHICH ARE NOT INCLUDED UNDER THE ORIGINAL PLAN OF CARE. IF THE PATIENT'S PHYSICIAN REFUSES TO SIGN A PLAN OF CARE WE HAVE FOUND THAT SOME HHAs SIMPLY FORGE HIS SIGNATURE TO THE DOCUMENT AND SUBMIT IT WITHOUT HIS KNOWLEDGE.

- THE OWNER AND OPERATOR OF AN HHA IN VIRGINIA HAD TO REPAY $40,000 SHE ILLEGALLY OBTAINED FROM MEDICARE AND PRIVATE INSURERS. SHE HAD FORGED PHYSICIAN'S SIGNATURES ON CLAIMS FOR SERVICES. HER CORPORATION WAS FINED $50,000.

5. KICKBACKS:

PATIENTS CAN USE A HHA OF THEIR OWN CHOOSING, BUT A "RECOMMENDATION" MADE BY A HOSPITAL DISCHARGE PLANNER, A SOCIAL SERVICES REPRESENTATIVE OR SOMEONE ELSE IN WHOM THE PATIENT OR THEIR FAMILY PLACE THEIR TRUST WILL CARRY GREAT WEIGHT.

HHAs MAY ARRANGE TO PLACE DISCHARGE PLANNERS IN HOSPITALS AT NO CHARGE TO THE HOSPITALS. THE DISCHARGE PLANNERS THEN REFER ALL PATIENTS TO THE HHA THAT PAYS THEIR SALARIES, UNLESS THEY RECEIVE SPECIFIC INSTRUCTIONS FROM THE PATIENT OR THE PATIENT'S FAMILY TO DO OTHERWISE. WE ARE INVESTIGATING ARRANGEMENTS SUCH AS THESE AS POTENTIAL VIOLATIONS OF THE MEDICARE ANTI-KICKBACK STATUTE.

6. ENTREPRENEURSHIP:

WE HAVE OBSERVED A PROLIFERATION OF BUSINESS ARRANGEMENTS WHICH ARE INTENDED TO ENHANCE THE INVESTMENT POTENTIAL OF HEALTH CARE RELATED BUSINESSES BY APPEALING TO INVESTORS WHO ARE IN A POSITION TO DIRECT A STREAM OF REFERRALS TO THEIR BUSINESS.

HOSPITALS, PHYSICIANS AND OTHER POTENTIAL REFERRAL SOURCES HAVE BECOME INVOLVED IN THE HHA FIELD AS OWNERS OR INVESTORS. FURTHER, WE HAVE SEEN A GROWTH IN TRANSACTIONS BETWEEN HHAs AND SUPPLIERS WHO SHARE COMMON OWNERSHIP IN AN EFFORT TO INFLATE THE AMOUNTS WHICH MEDICARE WILL REIMBURSE. THIS IS OFTEN A DIFFICULT SCHEME TO DETECT, EVEN BY THE MOST SKILLFUL AUDITOR.

7. INTERMEDIARY HOPPING

LAST YEAR, WE TESTIFIED BEFORE THIS COMMITTEE THAT THE PRACTICE OF "CARRIER SHOPPING" OCCURS IN THE DME INDUSTRY BECAUSE OF HCFA RULES AND REGULATIONS WHICH DETERMINE WHAT CARRIER HAS JURISDICTION OVER A PARTICULAR CLAIM FOR SERVICES. ALTHOUGH INTERMEDIARIES ARE RESPONSIBLE FOR PROCESSING CLAIMS FOR HOME HEALTH CARE SERVICES, WHETHER COVERED UNDER PART A OR PART B, THERE IS A SIMILAR PROBLEM.

HHAs ARE PAID DURING THE YEAR BASED ON THEIR ESTIMATED COSTS, AND THE INTERMEDIARIES MAKE FINAL SETTLEMENTS BASED ON THE AMOUNT OF ACTUAL COSTS FOUND TO BE REASONABLE UNDER MEDICARE'S COST-

REIMBURSEMENT RULES. BEGINNING IN 1979, HCFA ESTABLISHED LIMITS THAT MEDICARE WILL PAY FOR HOME HEALTH CARE. SEPARATE LIMITS ARE SET FOR RURAL AND URBAN HHAs BECAUSE COSTS TEND TO DIFFER BETWEEN THEM. ACCORDINGLY, HHAs KNOW IN ADVANCE THE MAXIMUM AMOUNT THEY CAN RECEIVE FOR PROVIDING EACH SERVICE.

CLAIMS FOR HOME HEALTH SERVICES ARE SUBMITTED TO THE REGIONAL MEDICARE INTERMEDIARY SERVING THE GEOGRAPHIC AREA IN WHICH THE HHA PROVIDING THE SERVICES IS LOCATED. THE HHA HAS THE RIGHT, HOWEVER, TO ELECT ANOTHER INTERMEDIARY UNDER CIRCUMSTANCES WHICH WOULD BE MORE EFFICIENT FOR CLAIMS PROCESSING. THIS CHANGE MUST BE APPROVED BY HCFA.

VARIATIONS IN COVERAGE POLICIES CAN LEAD TO THE PRACTICE OF "INTERMEDIARY HOPPING." UNDER THIS PRACTICE, HHAs SHOP AROUND, LEARNING AS MUCH AS THEY CAN ABOUT EACH INTERMEDIARY'S COVERAGE POLICIES. THEY LEARN WHICH INTERMEDIARIES PAY THE MOST FOR HOME HEALTH CARE IN AN EFFORT TO OBTAIN MAXIMUM REIMBURSEMENT FOR THEIR SERVICES. ARMED WITH THIS INFORMATION, SOME HHA CHAINS MOVE THEIR HOME OFFICE OPERATIONS TO A LOCATION SERVED BY THE INTERMEDIARY WITH THE MOST FAVORABLE COVERAGE POLICIES. THIS SUBVERTS MEDICARE GUIDELINES REGARDING INTERMEDIARY JURISDICTION.

QUALITY OF HOME HEALTH CARE

NOW I WOULD LIKE TO FOCUS MY REMARKS ON QUALITY OF HOME HEALTH

CARE. THE CONGRESS INCLUDED PROVISIONS IN THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (OBRA 1987) TO STRENGTHEN THE QUALITY OF HOME HEALTH CARE SERVICES. AMONG THESE WERE PROVISIONS THAT:

- REQUIRED SURVEYORS TO MEASURE THE IMPACT OF HOME HEALTH CARE ON PATIENT HEALTH TO EVALUATE THE QUALITY OF CARE;
- REQUIRED SURVEYORS TO VISIT PATIENTS' HOMES TO OBTAIN INFORMATION ON THE QUALITY OF CARE;
- GAVE HCFA A RANGE OF SANCTIONS TO IMPOSE ON HOME HEALTH AGENCIES THAT DID NOT COMPLY WITH HOME HEALTH STANDARDS;
- REQUIRED AGENCIES TO BE SURVEYED AT LEAST EVERY 15 MONTHS;
- REQUIRED THE SECRETARY TO DEVELOP TRAINING STANDARDS FOR MEDICAL EQUIPMENT SUPPLIER PERSONNEL.

HCFA IS PURSUING VARIOUS ACTIONS TO IMPLEMENT THE OBRA 1987 PROVISIONS. HCFA HAS ISSUED RULES DEALING WITH PATIENT RIGHTS AND THE TRAINING OF HOME HEALTH AIDES, AND A PROPOSED RULE ADDRESSING CONDITIONS OF PARTICIPATION AND SUPERVISION OF HOME HEALTH AIDES. HCFA HAS DEVELOPED NEW SURVEY INSTRUMENTS AND PROVIDED GUIDANCE TO STATE SURVEYORS IN ORDER TO IMPLEMENT THE REVISED SURVEY PROCESS; HOWEVER, NO REGULATIONS HAVE BEEN PROMULGATED.

TO GIVE THE DEPARTMENT FLEXIBILITY TO ENFORCE HOME HEALTH QUALITY STANDARDS, OBRA 1987 ESTABLISHED A RANGE OF SANCTIONS OTHER THAN TERMINATION FOR HOME HEALTH AGENCIES, INCLUDING (1) SUSPENSION OF MEDICARE PAYMENTS, (2) CIVIL MONETARY PENALTIES, AND (3) APPOINTMENT OF TEMPORARY MANAGEMENT FOR THE HOME HEALTH AGENCY. THE ACT DIRECTS THE SECRETARY TO DEVELOP SPECIFIC PROCEDURES THAT

SET FORTH THE CIRCUMSTANCES UNDER WHICH THESE SANCTIONS WILL BE APPLIED, MINIMIZE THE TIME BETWEEN IDENTIFICATION OF DEFICIENCIES AND IMPOSITION OF SANCTIONS, AND PROVIDE PROGRESSIVELY MORE SEVERE SANCTIONS FOR REPEATED OR UNCORRECTED DEFICIENCIES. IN AUGUST 1991, HCFA PUBLISHED A NOTICE OF PROPOSED RULEMAKING THAT STRENGTHENS ENFORCEMENT STANDARDS BY AUTHORIZING ALTERNATIVE SANCTIONS AND SPECIFYING SURVEY FREQUENCY.

OIG REPORTS

WE HAVE ISSUED SEVERAL REPORTS THAT RAISE CONCERNS ABOUT THE QUALITY OF HOME HEALTH CARE, WHICH I WOULD LIKE TO SUBMIT FOR THE RECORD. IN 1987, WE CONDUCTED AN INSPECTION TO LOOK AT THE TYPE AND NUMBER OF SERVICES PROVIDED TO MEDICARE BENEFICIARIES BY HOME HEALTH AIDES AND THE TRAINING AND SUPERVISION OF THE AIDES WHO ARE REQUIRED TO PERFORM THE NECESSARY SERVICES. HCFA NORMALLY EXPECTS STATE SURVEYORS TO COMPARE PLANS OF CARE FOR HOME HEALTH AGENCY PATIENTS TO CLINICAL RECORDS AND VERIFY THAT:

- REQUIRED SERVICES ARE PERFORMED;
- HHAs PROVIDE PROPER SUPERVISION TO HOME HEALTH AIDES; AND,
- SERVICES PROVIDED BY CONTRACT PERSONNEL ARE CONSISTENT WITH THE PLAN OF CARE.

THE FINDINGS IN OUR REPORT, "HOME HEALTH AIDE SERVICES FOR MEDICARE PATIENTS," RAISED SERIOUS QUESTIONS ABOUT WHETHER STATE SURVEYS CAN BE RELIED UPON TO ENSURE THAT MEDICARE PATIENTS RECEIVE QUALITY HOME HEALTH CARE:

- A REVIEW OF PATIENT RECORDS REVEALED THAT WHERE PLANS OF CARE CALLED FOR HOME HEALTH AIDES TO PROVIDE SPECIALIZED SERVICES IN SUPPORT OF CARE BY SKILLED NURSES OR PHYSICAL THERAPISTS, THE AIDES FAILED TO PERFORM HALF OF THESE TASKS;

- POOR SUPERVISION OF HOME HEALTH AIDES WAS THE PRINCIPAL CAUSE OF LESS-THAN-ADEQUATE CARE. SUBSTANTIAL WEAKNESSES WERE FOUND IN SUPERVISORY NURSE ORIENTATION OF AIDES IN THE MANNER IN WHICH THEY WERE TO ADDRESS PATIENT NEEDS; AND,

- AIDES UNDER CONTRACT TO AGENCIES DID NOT PERFORM THE MAJORITY OF SKILLED CARE TASKS ASSIGNED TO THEM.

THIS LACK OF CARE DEPRIVES THE MEDICARE PATIENT OF FULL HOME CARE, RESULTING IN A POSSIBLE DECREASED POTENTIAL FOR REHABILITATION OR INCREASED CHANCE OF READMITTANCE TO A HOSPITAL. WE, THEREFORE, MADE A NUMBER OF RECOMMENDATIONS TO HCFA -- WHICH ARE DISCUSSED BELOW -- TO HELP OVERCOME SOME OF THE PROBLEMS WE IDENTIFIED.

IN A 1988 REPORT ENTITLED "MEDICARE INTERMEDIARY REIMBURSEMENT TO HOME HEALTH AGENCIES FOR DURABLE MEDICAL EQUIPMENT," WE IDENTIFIED SEVERAL MEDICARE PAYMENT VULNERABILITIES ASSOCIATED WITH DME WHEN COVERED AS A HOME HEALTH BENEFIT. INCONSISTENCIES IN POLICIES BETWEEN PART A AND B FOR DME BENEFITS WERE THE CAUSE OF THESE PROBLEMS. WE RECOMMENDED THAT HCFA, THROUGH CONGRESSIONAL ACTION, SHIFT THE CLAIMS ADJUDICATION RESPONSIBILITIES FROM INTERMEDIARIES TO CARRIERS, FOR CONSISTENCY IN COVERAGE AND PAYMENT DECISIONS. ALTHOUGH WE UNDERSTAND THAT HCFA HAS ASKED FOR LEGISLATION WHICH WOULD ALLOW THEM TO IMPLEMENT THAT RECOMMENDATION, IT HAS NOT YET BEEN ENACTED. WE STRONGLY SUPPORT THAT ACTION.

IN A 1990 REPORT ENTITLED "MEDICARE - NEED TO STRENGTHEN HOME HEALTH CARE PAYMENT CONTROLS AND ADDRESS UNMET NEEDS," WE ASSESSED WHETHER ACTIONS TAKEN BY THE HCFA RESOLVED PROBLEMS NOTED IN AN EARLIER REPORT BY THE U.S. GENERAL ACCOUNTING OFFICE (GAO). THE PRINCIPAL GAO FINDING WAS THAT WEAKNESSES IN INTERNAL CONTROLS AT THE FISCAL INTERMEDIARIES AND HCFA CONTRIBUTED TO IMPROPER PAYMENTS OF AN ESTIMATED $600 MILLION FOR HOME HEALTH SERVICES. THE OIG FOLLOW-UP REVIEW DETERMINED THAT HCFA:

- HAD IMPLEMENTED THE GAO RECOMMENDATION TO CLARIFY HOME HEALTH COVERAGE CRITERIA AND WAS IN THE PROCESS OF IMPLEMENTING THE GAO RECOMMENDATION FOR NATIONAL PREPAYMENT UTILIZATION SCREENS FOR HOME HEALTH SERVICES;

- HAD NOT IMPLEMENTED THE GAO RECOMMENDATION TO USE STATISTICAL SAMPLING METHODS IN POSTPAYMENT REVIEWS OF HHAs.

- HAD IMPLEMENTED THE GAO RECOMMENDATION TO EXPAND THE CONTRACTOR PERFORMANCE EVALUATION PROGRAM (CPEP) TO ASSESS THE ACCURACY OF INTERMEDIARY HOME HEALTH COVERAGE DETERMINATIONS AND TO FURTHER STUDY FACTORS CONTRIBUTING TO UNMET NEEDS FOR HOME CARE ASSISTANCE.

IT IS OUR UNDERSTANDING THAT HCFA IS NOW IN THE PROCESS OF DEVELOPING MANUAL INSTRUCTIONS FOR FISCAL INTERMEDIARIES THAT WILL PROVIDE GUIDANCE FOR THE POSTPAYMENT SAMPLING OF HHAs. THE HCFA HAS WORKED WITH THE INDUSTRY IN DEVELOPING THESE INSTRUCTIONS AND THEY ANTICIPATE THAT THEY WILL BE PUBLISHED IN JULY, 1992.

RECOMMENDATIONS

WE HAVE MADE NUMEROUS RECOMMENDATIONS TO HCFA TO IMPROVE THE QUALITY OF HOME HEALTH CARE. WHILE WE UNDERSTAND THAT HCFA HAS TAKEN ACTION IN MANY AREAS, WE BELIEVE THAT FURTHER IMPROVEMENTS ARE NECESSARY. BECAUSE OF THE IMPORTANT ROLE PLAYED BY THE PHYSICIAN IN ARRANGING FOR HOME HEALTH CARE, WE BELIEVE THE PLAN OF CARE SHOULD BECOME A FORMAL DOCUMENT, SIMILAR TO THE CERTIFICATE OF MEDICAL NECESSITY USED IN PROVIDING OXYGEN SERVICES. WE ALSO BELIEVE THAT THE PHYSICIAN WHO CERTIFIES TO THE NEED FOR THESE SERVICES AND WHO SIGNS THE PLAN OF CARE SHOULD BE THE PATIENT'S TREATING PHYSICIAN, AND SHOULD BE ATTENDING TO THE PATIENT'S CARE ON A CURRENT AND REGULAR BASIS.

WE HAVE ALSO RECOMMENDED THAT HCFA:

- CONTINUE DEVELOPING PREPAYMENT UTILIZATION REVIEW SCREENS;
- GO FORWARD WITH THEIR INTENTION TO PUBLISH MANUAL INSTRUCTIONS FOR THE USE OF STATISTICAL SAMPLING METHODS IN POSTPAYMENT REVIEWS;
- ESTABLISH EFFORTS TO ENCOURAGE CONSISTENCY IN CLAIMS DETERMINATIONS FOR MEDICARE HOME HEALTH SERVICES, INCLUDING DEVELOPMENT OF REGULATIONS, TRAINING SESSIONS, AND REVISIONS TO MANUALS,
- LEGISLATIVELY, CONGRESS MAY WISH TO INCREASE CRIMINAL AND CIVIL PENALTIES FOR MEDICARE FRAUD. UNDER CURRENT LAW, FOR EXAMPLE, FALSIFYING COST REPORTS CAN ONLY BE CHARGED AS A SINGLE VIOLATION BECAUSE THE DOCUMENT IS ONLY SIGNED ONCE. SETTING SPECIFIC CRIMINAL PENALTIES FOR EACH FALSE ITEM IN THE COST REPORT WOULD ENHANCE PROSECUTION EFFORTS.

CONCLUSIONS

THE INTEREST OF THIS COMMITTEE IN EXAMINING ISSUES RELATING TO THE MEDICARE PROGRAM IS WELL PLACED. SINCE MEDICARE EXPENDITURES ARE CONTINUING THEIR UNPRECIDENTED GROWTH, WE MUST DETERMINE HOW WE MIGHT BEST PROTECT THE PROGRAM FROM FRAUD AND ABUSE. WE SHOULD ALSO CONSIDER HOW WE CAN ACCOMPLISH THIS GOAL WHILE ENSURING MAXIMUM COST-EFFECTIVENESS OF MEDICARE SERVICES.

HOME HEALTH CARE SHOULD BE ONE OF MEDICARE'S MOST COST-EFFECTIVE SERVICES BECAUSE IT OFFERS AN ALTERNATIVE TO THE HIGH COST OF INPATIENT NURSING HOME AND HOSPITAL CARE. HOWEVER, THE MAGNITUDE OF RECENT INCREASES IN HOME CARE EXPENDITURES HAVE LED US TO CONCLUDE THAT THIS TYPE OF NON-INSTITUTIONAL CARE MAY SOMEDAY BE JUST AS EXPENSIVE AS HOSPITALIZATION. ADDITIONALLY, UNRESOLVED ISSUES RELATED TO ENSURING QUALITY OF CARE THREATEN THE MEDICARE BENEFICIARY WITH RECEIVING FAR LESS THAN ADEQUATE CARE FOR THAT INCREASED EXPENSE.

THIS CONCLUDES MY PREPARED TESTIMONY. WE SHALL BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE.

Senator SASSER. I want to commend you for the work that you and your colleagues in the Office of the Inspector General have been doing in this particular area, with home health care service and other areas of investigation into the medicare system. I think that your work has been invaluable, and if anything, the Office of the Inspector General's staff needs to be expanded so that you can move into other areas and move forward with greater intensity.

Toward the end of your statement, you mentioned two previous reports, one by your office and one by the General Accounting Office.

Mr. COTTOS. Yes sir.

Chairman SASSER. They detail serious problems with home health care. You stated that according to your study, and I found this alarming, home health aides supporting home health nurses failed to provide half of the specialized services called for. In other words, these home health aides weren't providing half of the services that they were supposed to be providing.

Mr. COTTOS. That is correct.

Chairman SASSER. And you also stated, and I think this is a direct quote, that "aides under contract to agencies did not perform the majority of the task assigned to them."

Mr. COTTOS. That is correct.

Chairman SASSER. Now I think these statements really have very wide-reaching implications. In other words, what we are saying here is that these home health aides who are being paid to perform a certain function, are performing only half of the things that they are being paid to do.

Is that a fair statement?

Mr. COTTOS. When that report was done, that is accurate, yes sir.

Chairman SASSER. And that aides who are under contract to agencies did not perform—did not perform—the majority of the tasks assigned to them. Now in other words, they weren't performing the majority of the tasks that they were paid by medicare to perform, is that what you are telling this committee?

Mr. COTTOS. That is accurate, yes, Senator.

Chairman SASSER. Well, can you elaborate some on these statements? Is there evidence that these statistics are getting better, or have they worsened since your report was issued?

Mr. COTTOS. Well, we have not conducted any follow-up studies, Senator, since the 1988 report. However, HCFA has tightened the regulations and has put on some more requirements related to the training of home health aides to try to better control the situation and in fact make sure that we are getting what we are paying for.

Chairman SASSER. Well, is HCFA following up on this as vigorously as it should, in your judgment, Mr. Cottos?

Mr. COTTOS. They have the same problems that we do, Senator, as far as funding sources.

Chairman SASSER. Yes.

Mr. COTTOS. You know, running the program is a massive undertaking, and I think that all of us are operating with resources. I think that HCFA has taken some steps. Whether those steps are enough at this point is debatable, but I think any step is a step in the right direction.

Chairman SASSER. Well, for the benefit of those who may not understand all these acronyms, HCFA is the Health Care Financing Administration——

Mr. COTTOS. Yes sir.

Chairman SASSER [continuing]. And the Health Care Financing Administration has the responsibility not only of paying these claims, of paying for the home health care—they are the payor—but they also have the responsibility for enforcing the regulations——

Mr. COTTOS. That is correct, Senator.

Chairman SASSER [continuing]. And to eliminate any waste or abuse or fraud that might be available.

Now you say that you think HCFA may be doing a little better. I will ask you if HCFA has improved in their enforcement measures since we began our investigations last year, beginning with the durable medical equipment problems.

Mr. COTTOS. Yes, Senator, I think that the hearings you had last year, and brought those DME problems to the forefront and to the attention of HCFA and the government, the Congress. I think there has been some significant activity.

HCFA has now pushed the contractors, the people that actually pay the claims out in the individual States, to set up fraud detection units and is funding those units, which we think is a step in the right direction because that gives them more people and more budget to identify fraud, and the more identifying we get the more deterrent value we feel that we will have on the program.

So I think HCFA is taking some definite steps in that area in the last year.

Chairman SASSER. I am very pleased to hear you say that, because we had Dr. Wilenski, the Director of the Health Care Financing Administration, before the Budget Committee, before the full committee on at least two occasions, and I frankly did not think that she was aware of the magnitude of the problem in the field, particularly with regard to the durable medical equipment that we were investigating at that time.

I got the impression that HCFA was more concerned with paying the bills, which is very, very important obviously, but not as concerned about making sure that they were getting a full measure of worth for every dollar that they sent out the front door.

Mr. COTTOS. Yes; one of the other things that HCFA has done in the last year as a result of those hearings, Senator, has been to give the Office of Inspector General greater input into the review process that HCFA uses to review the contractors, and that the identification of fraud has now been made a critical element in the carrier review.

And again, this is something that we have emphasized for a long time and HCFA has now agreed with us and taken that step and is working with our office to allow us that input.

Chairman SASSER. Now Mr. Cottos, you indicated that all home health agency visits have to be authorized by a plan of care that is prepared by a physician. I understand that some of these plans of care are rather vague and leave much of the actual decisionmaking up to the nurse or agency providing the care.

As I said in my opening statement, we have heard from some doctors that they feel that some home health care agencies are providing unnecessary services.

My question to you is how specific are these plans of care? For example, does the doctor specify the number of visits to be made or the type or number of tests to be given? Is it likely, for example, that a doctor will ever know if more services are provided than he calls for and that more services are billed for than he or she calls for?

Mr. COTTOS. Yes, Senator. The plans of care that the physician makes up are definitely specific in the services that are to be provided. However, the problem comes in the fact that the physician is not there at the home to know exactly what services are provided, and he is also not privy to the billings that are sent in by the home health agencies.

So he writes out a specific plan of care, and all he can do basically is assume that it is being followed, because he is not physically on-site to supervise those services. So it puts the physician in a very bad position, and that is where we have the problem.

Chairman SASSER. What machinery is in place, if any, to see that the physician's regimen for care or the plan of care is adhered to and carried out specifically and not enlarged upon?

Mr. COTTOS. Well, the contractor has the responsibility to make sure that their people are doing the services that are being provided and to notify the doctor if they are not, and that is where the problem, I think, lies.

Chairman SASSER. So what you have then, as I understand you, is essentially a self-enforcing mechanism here.

Mr. COTTOS. Basically that is true, Senator.

Chairman SASSER. Now there the providers themselves are more or less on, for want of a better term, the honor system to see that they provide the services that are specified and no more.

Mr. COTTOS. I think it would be impossible to verify every service provided——

Chairman SASSER. Right.

Mr. COTTOS [continuing]. Under any program, and I think that there are some regulations and there are surveys done to follow up, but with the volume that is taking place right now, it is just impossible to verify every service.

So I think when you talk about the honor system, I think that is basically correct.

Chairman SASSER. So essentially we are putting out over $3 billion here a year, and in the final analysis we are relying on the good faith and honesty of the providers to see that that system works properly and that the taxpayers aren't taken advantage of.

Mr. COTTOS. That is correct, Senator.

Chairman SASSER. Well I must say to you, Mr. Cottos, that I have great faith in human nature, but quite frankly that stretches even my great faith to believe that with over $3.5 billion out there that there are not going to be at least some individuals who are going to try to take advantage of that and make as much money as they possibly can off of it.

It is my view that we need to have some better method, the Health Care Financing Administration needs to come up with some better method of trying to police these expenditures in the field.

Would you agree with that?

Mr. COTTOS. Yes, Senator, I would, and I think that the Health Care Financing Administration is writing up some new manuals to try to set forth some regulations to better control the system, when they saw the figures about how this dollar amount is going up.

Chairman SASSER. One of the most difficult problems that policymakers have is to try to draw the line between adequate monitoring of health care services to make sure that the medicare beneficiary and the taxpayer are getting what they are entitled to, to draw that line, between that and excessive regulation of these services. It seems like we can never quite get it right.

For example, I think most people agree it is reasonable to require a doctor to approve home health services, but many would disagree about whether or not a doctor should authorize every single service provided by a home health care nurse or therapist. Now under current rules, doctors are not even required to see the patients for which they prepare the plans of care. In other words, now a doctor can write a plan for care for a patient having never seen that patient?

Mr. COTTOS. I think what we are suggesting is that the attending physician is the physician who should be writing the plan of care to take care of the patient, and that gives us some control because they are the ones that actually see the patient, rather than having a physician who has never seen the patient write a plan of care.

Chairman SASSER. So we are having physicians write the plan of care who are not the attending physician——

Mr. COTTOS. Yes, Senator.

Chairman SASSER [continuing]. And they are not the ones who has had personal contact with the patient.

Mr. COTTOS. That is correct.

Chairman SASSER. Well do you think, Mr. Cottos, that the physicians themselves should play a greater role in monitoring home health care, and if so, what should their role be?

Mr. COTTOS. Well, I think again, getting back to what I just said about the attending physician being required to certify the patient's medical need and that the plan of care is correct is probably the best way to go, and I think that by doing this, this would ensure the physician most familiar with the patient is the one who is verifying the care and prescribing the care. That is what we see as the most important part of the physician's role.

Chairman SASSER. In reading your reports and your statement, I was a little surprised that the largest area of fraud that you identified dealt with the falsifying of yearly cost reports. I would have supposed that such activity would be fairly easy to catch in HCFA's standard auditing process.

What percentage of reports are audited by the Health Care Financing Administration's intermediaries?

Mr. COTTOS. I don't think we have a percentage, Senator. I think that one of the problems involved is as the cutback of funds takes place, there is less on-site work to be done.

When the intermediary has two ways to do it, they can do a desk audit of the cost reports, in which case the paperwork is submitted and they sit in the office and go through it. Obviously, that is not as detailed as an on-site audit. But I think with the cutback of funds available to do these audits, that they cannot go out on site. And by restricting that, by causing more desk audits and less on-site audits, I think that is where the problem comes out.

Chairman SASSER. In other words, you think they would be better off doing more on-site audits?

Mr. COTTOS. Absolutely. When you do the on-site audit, you can look up the backup vouchers which give more detail to what expenses are being claimed. But if you are just doing a desk audit, basically all you are doing is adding up the numbers——

Chairman SASSER. Of course, that would be more expensive, to put an on-site auditor out there.

Mr. COTTOS. That is correct, because normally you have to pay travel costs, et cetera.

Chairman SASSER. What is your opinion, and I won't ask you to speak for the Inspector General's Office in this instance, but just what would be your personal opinion as to whether or not that would be cost effective, to put more on-site auditors out there. Would you save more money by shrinking down the abuse and fraud than it would cost you to put more on-site auditors out or not?

Mr. COTTOS. Absolutely, Senator. I think that when we have gone on-site and gone into detailed audits, we have recovered much more than the amount that was embezzled from the program. So we definitely feel that being able to send the auditors out there and spend more time and go into more detail is definitely cost effective.

Chairman SASSER. Do you have any information about what percentage of these reports contain false information?

Mr. COTTOS. Again, it is only estimates. We have no real idea. The ones that we look at, we are probably looking at half, contain some amounts that should not be included in the cost report. Again, that can be small amounts, that can be large amounts. Almost without a doubt, it is at least a half.

Chairman SASSER. So you are saying that you think at least half of the audits, or half of the reports that come in, contain some overstatement of charges.

Mr. COTTOS. That is correct, Senator.

Chairman SASSER. As I mentioned, the committee has been contacted by home health care nurses who allege that they have been pressured to provide visits up to the amount that medicare or medicaid will allow rather than the amount they feel are medically necessary.

For example, as you know, they can make a certain number of visits—there is a maximum number of visits they can make and be paid for by either medicare or medicaid. These nurses say that their employers are pressuring them to make the maximum number of visits, even though that may not be necessary.

Now I would imagine that those kind of practices are very, very hard to identify and would be almost—very, very difficult to prosecute.

What measures does the Health Care Financing Administration have in place to identify providers who improperly maximize their billings, and are these measures sufficient, in your judgment?

Mr. COTTOS. Well, I think they are trying to do post-pay review after the claims are paid, to go back out and do a sampling of the claims that were submitted by the home health agencies to see if those services were actually rendered.

One of the problems that HCFA is having is when they find a problem like that, they try to do a sample and project an overpayment from that sample. Congress right now is looking into a bill which is saying that—it is an anti-sampling bill, I guess, which will prohibit the Department from using the sampling process.

I think that this is an effective tool that HCFA really needs to be able to sample, because again they can't look at every claim either, but by sampling then they can project the overpayment and get sufficient funds back, which has been justified in the past.

Chairman SASSER. How would the sampling work?

Mr. COTTOS. The sampling would work like this, for example. You could take a sample of roughly 100 claims—remember that the actual number is determined using statistically valid techniques—and verify whether those services were provided or not or if they were excessive or not, and if you found 40 percent were not rendered or there was no documentation for those services, then you could project an overpayment of 40 percent of what the provider had billed, and then you could try and recover that money from the provider. That is the way the sampling basically works. Let me emphasize once more, however, that the actual process involves very complex statistical techniques which achieve results that can be defended in court, if necessary.

Chairman SASSER. Right. It would be sort of like taking a poll, in the sense that when you take a poll you take a sample slice of the population and then extrapolate from that sample slice what the majority or what the population in general thinks.

Mr. COTTOS. That is correct, Senator.

Chairman SASSER. So you are trying to use this same principle to sample the——

Mr. COTTOS. The services that are billed to the government, that is correct.

Chairman SASSER. Who is opposing that?

Mr. COTTOS. There is a bill in the House and the Senate which have been pushed forward to prohibit the Department from using the sampling.

Chairman SASSER. How often are home health agencies visited by officials who monitor their work, and are such visits announced?

Mr. COTTOS. The requirement is every 15 months, and basically they are visited every year. The problem is that they are announced, and mostly the State surveyors go out and conduct those reviews, but because of a lot of the State regulations they are announced, and we feel that this is one of the problems, that it would be much more effective if it was unannounced, if you just showed up rather than saying, I am going to be there, so that they can correct any problems before you get there.

Chairman SASSER. So they know when you are coming so they—it is like when I was in the military. If we knew when the inspection was coming, the barracks was always spit-and-polish clean.

Mr. COTTOS. That is correct, Senator.

Chairman SASSER. But if we got a surprise inspection, sometimes things weren't so ship-shape.

Mr. COTTOS. That is exactly correct.

Chairman SASSER. You will recall that kickback arrangements were commonplace in our investigations of durable medical equipment. Now the possibility of kickbacks, referral, or self-referral arrangements in home health care can be equally troubling.

Over the last several years, anti-self-referral laws have been passed for a number of specialties, such as physicians referring patients to clinical labs in which the physician owns an interest.

For example, something that comes to mind would be perhaps the hematologist referring patients to a blood lab in which he or she is the principal.

Now do any such self-referral laws exist for ownership in home health facilities?

Mr. COTTOS. Physicians who own or hold significant financial interests in a home health agency are prohibited from signing the certificate of need or plans of care. However, there are no anti-referral laws at this time for this aspect of the health care industry.

Florida has got a bill in process now about self-referrals which is going to limit things, but that is strictly a State bill in Florida.

Chairman SASSER. You say there are prohibitions from a physician referring a home health care agency that he or she might have an interest in, but there is no law against that.

Mr. COTTOS. That is not quite correct.

Chairman SASSER. Well how is this prohibition enforced?

Mr. COTTOS. There is a prohibition against a physician who owns or holds a financial interest in a home health care agency signing the certificate of need or the plan of care—the documents which ultimately cause payment—but there is no law against that same physician referring a patient to the home health care agency in which he has a financial interest. We believe that a law prohibiting self referral is needed.

Chairman SASSER. I see. I noticed for all the convictions for criminal activity that you cite in your testimony, as well as most of the home health fraud convictions that I have heard of independently, the punishments almost never include prison terms.

Now it appears to me that jail time or at least permanent revocation of home health care licenses would be a significant deterrent to those considering home health fraud. What is your reaction to that?

Mr. COTTOS. I think things have changed in the last few years on two fronts, really. Number one, the sentencing guidelines went into effect a couple of years ago, and that standardized the sentences that would be received.

For instance, in the Southern District of Florida the sentence would be the same as the Middle District of Tennessee because of the sentencing guidelines, because it lays everything out regarding what kind of fraud was committed, the amount of money involved, et cetera.

The other way that things have changed are that we have gotten much more active in the civil side, so that not only doing the criminal case but we have also started to aggressively pursue the civil side to get the money back, and I think those two things are going to act as stronger deterrents in the future.

Chairman SASSER. Thank you, Mr. Cottos. Frankly, from your testimony it appears to me that the lack of enforcement and the lack of supervision that you have outlined here is really not fair to the ethical home health care provider.

For example, the home health care provider that is trying to do their best, trying to adhere to the regulations, trying to serve their client in the most cost-efficient and cost-effective way to medicare, at the same time they are being outrun financially by a competitor who is not as ethical and who cuts corners and pads the bill. They see their competitor making more money and expanding their services all the time.

So the failure, I think, to not have more stringent enforcement measures here really works to the detriment of the ethical providers of home health care, it would appear to me. Would you agree with that?

Mr. COTTOS. I agree with that statement, Senator. Yes, I do.

Chairman SASSER. Well Mr. Cottos, thank you very much for appearing here today and giving us the benefit of your views. I look forward to continuing to work with you and your colleagues in the Inspector General's Office as we deal with this problem and other problems in the medicare system. Thank you very much.

Mr. COTTOS. Thank you, Senator.

Chairman SASSER. Our next witness this morning will be Ms. Gayla M. Sasser, who I indicated earlier is the Executive Director of the Tennessee Association for Home Care, Incorporated, here in Nashville, TN.

Ms. Sasser, we want to welcome you here this morning. We look forward to your presentation. You may proceed in any fashion that you wish.

STATEMENT OF GAYLA M. SASSER, EXECUTIVE DIRECTOR, TENNESSEE ASSOCIATION FOR HOME CARE, INC., NASHVILLE, TN

Ms. SASSER. Thank you, Senator. Just for the record, certainly I would be happy to be related to you. The last few weeks, I wished we were related.

I do thank you for the opportunity to provide information about the home care industry in Tennessee. Just a little bit about our association. We do represent all facets of home-provided services in Tennessee. That includes home health agencies, home medical equipment suppliers, infusion suppliers, hospice services, and a host of support companies that go into the home setting.

For the record again, our membership supports Senator Sasser's efforts to eliminate any fraud and abuse within our industry or the health care industry as a whole. We, too, are concerned about the rising costs of health care.

To this end, we have identified several possible areas requiring attention, and we would recommend the Senator's intervention if at all possible.

But before I get to these recommendations, I would like to simply note that there are distinct players in the home care industry and say a little bit about each of those.

The provider of medical services is the home health agency, and most of the conversation this morning has been concerning home health agencies. They do send nurses, therapists, social workers, and home health aides into the home, and they bill Medicare Part A.

At this point, I would like to again for the record state that home health agencies cannot provide any services in the home without a physician's order. They cannot decide that they want to change the number of visits or the type of services that the physician originally ordered without another order from him. And if they do, it would be considered fraud and abuse.

The supplier of medical equipment and supplies is the home medical equipment or infusion therapy supplier, and they bill Medicare Part B.

Therefore, you have a provider and a supplier, and there are multiple State and Federal rules governing the operation of each of these. I would first like to talk about the rules that affect home health agencies, and the reason I want to discuss this is simply to point out that there are a number, numerous State and Federal regulations already that govern the operation of the agencies.

The first one is the Tennessee Health Facilities Commission. In Tennessee, you cannot open a home health agency until you prove that there is a need for another agency in the State.

The second is the Board for Licensing Health Care Facilities. This State agency, which is under our Department of Health, licenses and regulates home health agencies with 21 pages of regulations that governs operations, personnel, clinical, and quality issues.

Licensure annually audits each home health agency to be sure they comply with these State licensure rules. Licensure also contracts with HCFA to review annually for compliance with the medicare conditions of participation, and the Office of Inspector General talked about, at some length, about these particular rules.

Also, an agency can be audited at any time that a complaint is filed with the State hotline or with the Licensure Division. Some of the new Federal rules that the Inspector General discussed include a requirement that each State have a hotline and that each patient is given that hotline number on admission. They then can call Licensure and report anything that they feel is out of kilter throughout their service.

In addition, Licensure also looks at any other company that may provide services in the home. In Tennessee, only a home health agency can provide nursing, therapy, social services, and home health aide. That is not the way it is nationwide.

Thirdly, the Medicare Bureau also has annual audits of home health agencies. Auditors review to see that agencies are complying with the medicare regulations, which are often different from the medicare regulations and different from the Licensure regulations.

Agencies are also audited by the State Comptroller's Office concerning the medicaid cost reports. They are reviewed throughout the year for any non-covered services or non-compliance and on an

as-needed basis by the Medicaid Division of Quality Control. This is their program integrity unit that in Tennessee works with the TBI. They can also refer to the Office of Inspector General.

I have talked to medicaid in the last week, and they informed me that there has only been one potential fraud and abuse case in the home health industry in Tennessee in the last 8 years. That particular case is pending in Federal court right now, following a 2-year investigation by State and Federal governmental entities.

Chairman SASSER. Which case is that, Ms. Sasser?

Ms. SASSER. I believe the defendant's name is Tom Henry.

Chairman SASSER. Yes.

Ms. SASSER. Fourthly, there is a peer review organization. It is in Memphis. That entity contracts with the Health Care Financing Administration to look at quality care issues. They have a generic quality screen that is developed by HCFA, and if a patient is discharged from a hospital and then readmitted within 31 days and the home health agency provided services within that time period, their case may be selected by the PRO to be reviewed. The PRO, if they find anything, can refer it to their quality committee for further action or can refer it on to the Office of Inspector General.

Again, I have talked to the PRO in the last week, and they tell me that there have been no home health cases requiring the PRO quality committee review or Inspector General investigation in Tennessee.

I will move on to the Federal agencies. We have already discussed at length the Health Care Financing Administration. I believe we all understand their role. They basically implement the medicare and medicaid laws that Congress passes, and then they implement the regulations governing those laws.

They do contract with a fiscal intermediary, and for most Tennessee home health agencies, that fiscal intermediary is Blue Cross/Blue Shield of South Carolina. There used to be only ten FIs, I believe there are only nine now, and that is nationwide.

This body also monitors submission of patient claim forms. My understanding is that they have what they call a focused medical review in their computer system that would signal any claims with visits beyond the average number for a given diagnosis. They annually audit sample patient care charts.

Again, in my conversation with them, due to budget cuts they have had to cut back on the number of reviews that they have been able to perform in the last year.

They also annually audit the medicare cost reports to justify expenditures the agency makes, and they do routinely make recoupments if the agency has included something in their cost report that medicare feels is unreasonable.

They also have a program integrity unit, and so agencies are reviewed on an as-needed basis by this unit. That works directly with the Office of Inspector General.

Thirdly, the Occupational Safety and Health Administration, OSHA, regulates safety issues in the home setting through another set of Federal laws and rules, and they too have surveyors and investigators in their office.

And lastly but certainly not least is the Office of Inspector General, who does liaison with all these different State and Federal bodies concerning fraud and abuse.

From this extensive list of regulatory bodies, it is simply very difficult to understand why there should or could be any ongoing fraud and abuse. The members of our association agree to meet State and Federal laws, and we represent the majority of home health care agencies in Tennessee.

Just a little bit about home medical equipment suppliers and infusion, because we do represent their interests. Home medical equipment has certainly been investigated fairly thoroughly in the last year-and-a-half, and Senator Sasser has not only launched that but is continuing that. Because of that investigation, there are some new regulations or new laws pending in Washington.

The first one, of course, you certainly are familiar with, it is your own, the Medicare Durable Medical Equipment Act of 1991. Basically that would develop uniform standards for coverage, regional carriers, disclosure requirements, and a prohibition on carrier forum shopping.

The National Association for Medical Equipment Suppliers, NAMES, has also introduced a bill that has a lot of the same requirements that the Senator's bill has in it.

Our association went on record almost as soon as the bill was introduced in Washington supporting these efforts. Our home medical equipment suppliers agree with the regionalization of medicare carriers. This is very much like the fiscal intermediary process for home health, so it is not foreign to them at all.

We also are looking at our State level about licensure requirements.

Home infusion therapy suppliers—I do have a question about whether or not all the new home medical equipment laws would apply to the home infusion suppliers. They provide IV poles and some equipment to the patients as well as antibiotics and narcotics in the home setting. I am assuming at this point that the medical equipment act would also apply to that category of provider.

And I want to mention again that in Tennessee we do have very stringent licensure laws that would prohibit these infusion companies from providing nursing services. That is not the way it is nationwide.

Lastly, in addition to all these State and Federal rules, our members agree to abide by our own set standards, and that includes a code of ethics. Standards for home care, home infusion, safety, inspection, exposure, and social work. These are standards that our own industry has developed at the local level.

I am going to try to wrap up here, but I would like to make some recommendations based on what I have seen in the last 8 years in my role as executive director and also after interviewing all the different regulatory bodies that I have just referenced.

Number one, we feel that there should be some assurance that adequate funding is available to the governmental entities responsible for controlling fraud and abuse. Often, the budget cuts made to these bodies include significant cuts in their ability to provide ongoing reviews, and that has been very apparent in my discussions with Blue Cross of South Carolina.

Chairman SASSER. So you say that there ought to be adequate funding at the Federal level for those agencies or the branches of the agencies that are responsible for enforcement and investigation of fraud and abuse?

Ms. SASSER. That is correct.

Number two, we feel that there should be a control on the types of providers that are able to bill medicare for home care services. Again in Tennessee, we require home health licensure of any entity that provides medical services in the home setting, but this is not the way it is nationwide, a good example being home infusion. In some States, the nursing services are totally unregulated.

Number three, we would like to recommend that Senator Sasser continue his work to control the practices of home medical equipment suppliers. I think many positive changes are already taking place, and that should be continued.

Last, there should be some type of formal process for the regulatory agencies to share information concerning potential fraud and abuse. There appears to be a sufficient number of regulations, but the communication between the regulatory bodies is very informal and haphazard.

There is also a numerous amount of State and Federal bodies that are responsible for the same fraud and abuse reviews. Couldn't we combine these efforts and perhaps save some dollars and some resources and support communication in the investigation process? We feel like this possibly could speed up the investigation process and bring any such instances to a speedier conclusion and save the non-fraudulent entities the embarrassment of a long and drawn-out case that does reflect badly on the entire industry.

I would like to make just a couple of comments about the increasing expenditures. The association provided the Senator with at least our reasons that we felt the medicare expenditures were increasing, and I won't go into those in any detail other than to simply reference the DRG rates for hospitals and the 1988 Federal court decision in the Staggers lawsuit. Both of those issues have caused increased expenditures.

I did review last week a new report that was put together by the Hospital Insurance Board of Trustees, and they have projected that the increase in expenditures in home health will continue until 1993, but after that there will only be a modest increase that is caused by the natural growth and aging of the population. I have included in my written testimony the actual chart [1] that was developed by this study, and it does show an evening out of the expenditure projections through the year 2015.

I would be happy to respond to any questions the Senator may have.

Chairman SASSER. Well thank you very much, Ms. Sasser, and I think you have made some very constructive suggestions here today in your testimony, and we will take those certainly into consideration.

[The prepared statement of Ms. Sasser follows:]

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[1] See p. 54.

Testimony for The Honorable James R. Sasser
May 16, 1992
from Gayla M. Sasser, Executive Director
Tennessee Association for Home Care, Inc., Nashville

Gayla M. Sasser
Executive Director

Thank you for the opportunity to provide information concerning the home care industry in Tennessee. The Tennessee Association for Home Care represents all facets of "home provided services" in our State with over three hundred eighty (380) member companies. Certainly our membership supports Senator Sasser's efforts to eliminate any fraud or abuse that may exist within our industry or the health care industry as a whole. To this end, we have identified several possible areas requiring attention and recommend the Senator's intervention if at all possible.

Before identifying these areas, it is critical to note that there are distinct players in the home care industry:

1. The provider of medical services is the HOME HEALTH AGENCY, who sends nurses, therapists, social workers, home health aides into the home to provide medical services ordered by a physician. These providers bill Medicare Part A for their services.

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2. The supplier of medical equipment/supplies is normally a HOME MEDICAL EQUIPMENT OR HOME INFUSION THERAPY SUPPLIER. These companies provide the equipment and supplies needed for the home care patient to remain at home for their health care needs. These suppliers bill Medicare Part B for their supplies/equipment.

Therefore, you have a PROVIDER and SUPPLIER of home care services/supplies and equipment and different regulations that apply to each. For the PROVIDER of medical services, (the HOME HEALTH AGENCY), there are multiple state and federal regulations governing the operation and quality of services provided to the patient. A sampling of the governmental entities reviewing the home health agency's operation includes:

HOME HEALTH AGENCIES

STATE REGULATORY REVIEWS

1. **TENNESSEE HEALTH FACILITIES COMMISSION:** The State Agency that approves a Certificate of Need authorizing the development of any new home health agency(s) in our State. You must have a Certificate of Need as a home health agency BEFORE you can apply for Licensure. This process assures that only those health services NEEDED in our State are developed.

2. **BOARD FOR LICENSING HEALTH CARE FACILITIES:** The State

Regulatory Board (under the Department of Health) that licenses and regulates home health agencies according to the Minimum Standards for Licensing Home Health Agencies (21 pages of state regulations governing operations, personnel, clinical and quality issues). Home Health Agencies are:

a. Audited annually for compliance with the State Licensure regulations. (Licenses are renewed annually on July 1st)
b. Audited annually for compliance with the Federal Conditions of Participation for Medicare. (This audit is for Medicare certified home health agencies only, which includes the majority of agencies in Tennessee.)
c. Audited at any time a complaint is filed with the State Hotline or Licensure Division.

In addition, our State Licensure Division investigates all companies that may provide health services in the home. Under Tennessee law, only a HOME HEALTH AGENCY can provide the following services in the home:

a. Skilled Nursing
b. Physical, Occupational or Speech Therapy
c. Medical Social Services
d. Home Health Aide

It is Licensure's responsibility to assure that only licensed Home Health Agencies provide these home services to Tennesseans.

3. **MEDICAID BUREAU:** The State entity that pays Medicaid home health claims and monitors compliance with regulations governing quality, coverage and reimbursement issues. Home Health Agencies are:

   a. Audited annually by the Medicaid Bureau's Quality Care Auditors for compliance with Medicaid regulations.

   b. Audited annually by the State Comptroller's Office concerning Medicaid cost reports.

   c. Reviewed throughout the year for any non-covered services or non-compliance with Medicaid regulations through the Medicaid billing documents.

   d. Reviewed on an "as needed" basis by the Medicaid Division of Quality Control. This Medicaid "program integrity" unit reviews abuse and potential fraud cases and works with the Medicaid Fraud Control Unit (which is part of the TBI in Tennessee). Sometimes these units work with the Office of Inspector General on potential fraud cases. Our Medicaid Bureau has developed a process to communicate with other state regulatory bodies concerning potential abuse or fraud cases.

According to our Medicaid Bureau, there has been only one potential fraud and abuse case in the home health industry. That case is pending in federal court at the present after a two year investigation by state and federal governmental entities.

4. **PEER REVIEW ORGANIZATION:** Contracts with the Health Care Financing Administration (HCFA) to perform "quality care" reviews. The reviews are based on "generic quality screens" developed by HCFA. Should a home health agency provide care to a patient who is readmitted to the hospital within 31 days of discharge, the care may be reviewed by the PRO as an "intervening care" provider. The PRO has physician advisors who review the care and make recommendations to the provider or in a serious case, would refer the case to the PRO Quality Committee for further action. This Committee can refer cases to the Office of Inspector General.

   According to the PRO, there have been no home health cases requiring the PRO Quality Committee review or Inspector General investigation.

FEDERAL REGULATORY BODIES

1. **HEALTH CARE FINANCING ADMINISTRATION (HCFA):** Implements the Medicare and Medicaid laws/regulations governing home health services and provides policy/interpretation clarification to the industry on same. HCFA contracts with a fiscal intermediary (FI) to handle Medicare reimbursement/coverage

audits in home health and with State Licensure to audit for compliance with the Medicare Conditions of Participation.

2. **FISCAL INTERMEDIARY:** The FI for most Tennessee home health agencies is Blue Cross/Blue Shield of South Carolina. There are only ten (10) FIs across the nation. The FIs review home health services by:
   a. Monitoring the submission of patient claim forms. This is basically a daily process and currently the FI has a "focused medical review" process that "signals" any claims with visits beyond the "average" number for a given diagnosis.
   b. Annually audits sample patient care charts to determine reasonable and necessary services are being provided. Due to budget cuts, the FI is currently reviewing only 30% of the agencies under their jurisdiction.
   c. Annually auditing Medicare cost reports to justify expenditures the agency makes.
   d. Reviews on an "as needed" basis any potential fraud and abuse through their "Program Integrity Unit". This unit works with the Office of Inspector General on fraud cases.

3. **OCCUPATIONAL HEALTH & SAFETY ADMINISTRATION:** Regulates safety issues in the home setting through federal laws/regulations protecting the "patient".

4. **OFFICE OF INSPECTOR GENERAL:** Inspects and liaisons with other state and federal regulatory bodies concerning fraud and abuse.

From the extensive list of "regulatory bodies" governing the operation and services provided by HOME HEALTH AGENCIES, it is difficult to understand why there should or could be any ongoing fraud and abuse. The members of the Tennessee Association for Home Care agree to meet the state and federal laws/regulations governing our industry. Our membership represents the majority of the home health agencies in Tennessee (approximately 70%).

HOME MEDICAL EQUIPMENT SUPPLIERS

Although not as regulated as the home health agencies, there are currently legislative bills in Washington to increase the regulatory reviews for home medical equipment. Senator Sasser launched a national investigation last year and as a result has introduced S. 1736, the "Medicare Durable Medical Equipment Act of 1991, which promotes development of uniform standards for coverage, regional carriers, and disclosure requirements and a prohibition on carrier forum shopping. The National Association for Medical Equipment Suppliers (NAMES) has also introduced legislation (H.R. 2534, "The Ethics and Treatment Act of 1991). This bill would

amend title XVIII of the Social Security Act to impose standards relating to the prevention of fraud and abuse by suppliers of home medical equipment. Key provisions of the bill include:

1. Establishes accreditation and/or licensure of home medical equipment suppliers by January 1, 1994. Medicare payments would only be made to those suppliers certified by HCFA or licensed or accredited by a duly authorized quality assurance organization. HCFA is directed to publish the certification standards by January 1, 1993.
2. Prohibits FORUM shopping: Would prohibit a supplier from filing a claim in a state other than the beneficiary's home state.
3. Prohibits physician self-referral to HME suppliers.
4. Would target prohibition on distributing completed or partially completed Certificate of Medical Necessity (CMN) forms to physicians.
5. Requires oxygen retesting to confirm continued need for long term oxygen use.
6. Clarifies the capped rental reimbursement system for HME suppliers.
7. Implements 15% floor on reimbursement reductions tied to 1990 fee schedules.
8. Sets dollar floor on unassigned claims submission.

TAHC has gone on record supporting these efforts, in particular the regionalization of the Medicare carriers to prevent forum shopping and some type of "standards" such as those in the Joint Commission of Accreditation for Healthcare Organizations (JCAHO) accreditation process. We are also currently reviewing the need for a state licensure process for HME providers in Tennessee.

HOME INFUSION THERAPY SUPPLIERS

Most of the suppliers in this category should fall under the definition of a home medical equipment supplier and would probably be held accountable to the laws/regulations referenced above. However, in Tennessee, we also have stringent licensure laws to prevent the infusion supplier from providing any skilled nursing services UNLESS they are licensed as a HOME HEALTH AGENCY. We understand that many States do NOT have this requirement, which we feel is critical to maintaining the quality standards for home nursing referenced under the home health agency regulatory reviews. We would encourage ALL states to incorporate this requirement.

In addition to the various state and federal regulations, Members of the Tennessee Association for Home Care also agree to abide by the following TAHC standards, including:

1. A Code of Ethics
2. Standards for Home Care
3. Standards for Home Infusion Therapy
4. Standards for Safety, Infection and Exposure Control
5. Standards for Social Work

We understand that the Senator is reviewing all types of home care services and will be happy to provide additional information on any entity that falls under the definition of "home care" in Tennessee. Because we have very stringent licensure laws, only those entities that qualify as a HOME HEALTH AGENCY (and are licensed as such) are allowed to provide medical services to patients in their homes. We believe that this law should apply nationwide to provide the regulatory controls necessary to protect the "home care patient" we serve.

In addition, we would recommend the following to control fraud and abuse issues for our home care patients:

1. Assure that adequate funding is available to the governmental entities responsible for controlling fraud and abuse. Often, the budget cuts made to the regulatory bodies include significant cuts in their ability to provide ongoing reviews.

2. Control the types of providers that are able to bill Medicare for home care services. Again, in Tennessee, we require home health licensure of any entity that provides medical services in the home setting.

3. Continue the work begun by Senator Sasser to control the billing practices of home medical equipment suppliers.

4. Create a formal process for the regulatory agencies to share information concerning potential fraud and abuse cases. There appear to be sufficient regulations governing fraud and abuse, however, the "communication" between the regulatory bodies seems to be more on an informal basis. There are also numerous state and federal regulatory entities responsible for the same fraud and abuse activities. Could there be a combination of efforts to conserve dollars/resources and support communication in investigation cases? Perhaps this would speed up the investigation process to bring any such instances to a speedier conclusion and save the non-fraudulent entities the embarrassment of a long and drawn out case that reflects badly on the entire industry.

INCREASING EXPENDITURES

The Medicare expenditures for home health services are indeed on the rise. The reasons for this increase seem to mainly stem from the following:

1. Diagnostic Related Grouping (DRG) rates for hospitals: Patients are being released from the hospitals at a higher acuity level than ever before in our health care history. Home health services are ordered by physicians to assure that patients released from the hospital receive the medical care needed for their specific diagnosis in their own home. This

type of "home care" has proven many times over to be more cost effective than institutional care so the "switch" from hospital to home health care should be realized cost savings in another area of Medicare.

2. The 1988 federal court decision in the Staggers Lawsuit (Duggan v. Bowen):
   This court decision redefined HCFA's "part time or intermittent care" guidelines for home health benefits and determined that the Health Care Financing Administration (HCFA) was interpreting home health regulations too stringently. This "stringent interpretation" resulted in Medicare home health patients receiving less services than Congress intended under the Medicare law. We believe the increase in expenditures would have had a "steadier" increase over the years had Medicare home health patients received the benefits to which they were entitled all along.

3. Following the court case, the Medicare Home Health Policy Manual was rewritten in accordance with Judge Stanley Sporkin's decision in the Staggers lawsuit, which clarified coverage for home health services under the Medicare benefit. This lawsuit provides for extended eligibility and coverage for home health patients under the Medicare benefit and certainly promoted an increase in Medicare expenditures.

Please note that according to HCFA data, the average charge per home health visit accounted for only a small part of the growth in home health expenditures. Instead, HCFA cited greater numbers of beneficiaries served and more visits per patient as a reason for increased spending for Medicare home health patients.

According to actuarial estimates prepared for the annual report of the Hospital Insurance Board of Trustees, significant increases in Medicare home care benefit payments will continue through 1993 before resuming a more modest rate of growth.

The estimates signify the end of a period of accelerated growth following the Staggers lawsuit. Expenditures increased 47% in 1990, the first full year that the total impact of the new clarified policies were felt. Growth rates are projected to remain in double digits until 1993, after which only modest increases, caused by growth and aging of the population, are expected. (See chart for expenditure projections.)

The estimates were prepared as part of the annual report of the financial status of the trust funds used to pay Medicare benefits. These taxpayer-financed trusts, provide health care benefits for more than 40 million elderly and disabled Americans.

Percent Increases in Medicare Expenditures

(percents represent increases from the previous year)

Year	Inpatient Hospital	Skilled Nursing Facility	Home Health Agency
1987	4.6%	9.0%	-0.4%
1988	5.9	51.8	8.0
1989	8.1	258.1	24.0
1990	7.1	-29.3	47.0
1991	n/a	n/a	27.0
*1992	9.3	6.3	20.1
1993	9.3	6.0	15.3
1994	11.2	5.9	8.9
1995	11.1	6.1	9.1
2000	9.5	6.2	8.8
2005	8.3	5.8	8.3
2010	8.4	5.5	8.0
2015	9.2	5.6	8.2

* Percentages from 1992 - 2015 are based on projections.
Source: 1992 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund, April 1992

Senator SASSER. Your testimony indicates that your industry has a code of ethics already in place, at least for the members of your association. Are there people in the home health care business who are not members of your association?

Ms. SASSER. Yes, there are.

Chairman SASSER. What percentage, or do you have an estimate of the percentage of groups that are in the home health care business who are not members of the Tennessee Home Health Care Association?

Ms. SASSER. Our membership represents approximately 70 percent of the home health care agencies. I do not have projections on medical equipment and infusion.

Chairman SASSER. So those who would not be members of your association would not be subject to your code of ethics, obviously.

Ms. SASSER. That is correct.

Chairman SASSER. Is the code of ethics enforced within the industry by the association, or is it a voluntary compliance?

Ms. SASSER. It is more or less a peer review system. The association accepts complaints about other member agencies and an investigation does take place. In most cases, we have found that the complaints have been able to be worked out. Perhaps a physician is disgruntled because his paperwork is mounting on his desk and he feels like the agencies are sending him too much work to do, which is a legitimate concern.

When you talked earlier about the physician involvement in home care, the paperwork that he has to complete for our services is ridiculous, and the physician community is very upset with that, which makes it harder for us to get our orders signed, but that is the process as it stands today.

Chairman SASSER. That is something that really must be dealt with. By some estimates—well frankly, by just about all estimates—anywhere from 25 to 40 cents out of every dollar spent for health care in this country goes to the administrative cost. That is, filling out the forms, filing the forms properly, auditing the forms on the part of the payor.

It is just an extraordinary burden on the whole health care system, and a lot of health care dollars simply are not getting down to where the rubber meets the road in actually treating the person that needs to be treated because of the administrative cost.

Yet on the other hand, we have the problem of if we don't enforce some sort of standards, then we are opening the system up to even further abuse.

So trying to find that golden mean is a very, very difficult process indeed, and I do think that in the final analysis, just the superstructure of this great administrative burden is going to be one of the things pushing this country in the direction of a more simplified and universal health care system at some time in the future. I don't know what kind of configuration it is going to take, but there are going to be, I think obviously, some changes.

You mentioned several areas, Ms. Sasser, where Tennessee standards for preventing abuse are more rigorous than the national standards. Do you think the Tennessee standards should be adopted at the national level?

Ms. SASSER. Yes, I do.

Chairman SASSER. We found in our investigation of durable medical equipment that the payor here in Tennessee was doing a better job of trying to police the DME field than we found in other States. I don't know whether that is a result of just better ethics here in the State of Tennessee or the fact our resources are thinner and we have to stretch them further and get more bang for the buck. I don't know the answer to that, but we do have a little better record here I think than they have in other States.

Now your testimony indicates, as I heard it here today, that little if any fraud should or could be going on in home health care. Yet we have the Inspector General here from Atlanta telling us of a number of areas that he feels are the subjects of abuse.

One of the areas that concerns me the most is the possibility of excessive billing. By that, I mean an agency might bill for an unneeded test or provide more visits than are medically necessary.

Even though home health—let us just concede that the home health business is as highly regulated as you point out, some agencies are finding ways to game the system for profit. I don't think there is any question about that.

What is the best way of singling out those agencies without adversely affecting the vast majority of home health providers who are conducting their business in an ethical way? How would you suggest we go about trying to screen out the bad apples? Would aggressive auditing be the answer? Would more frequent visits by inspectors be the answer? Would it be a combination of the two? Do you have any suggestions about how we could handle that problem?

Ms. Sasser. Well Senator, again I feel like we have a vast number of regulatory entities that are trying to audit and investigate. I feel strongly that if we combined those efforts, we would have a greater chance of perhaps detecting fraud and abuse early on instead of much after the fact, as it normally occurs—more of an up-front review than a back-end review.

Just let me ask you this question, for example. Once a home health agency receives a plan of care from a physician, the doctor fills out the plan of care, does the home health care agency visit the patient for a specified number of visits, or does the agency use its judgment to determine how many visits are necessary?

Ms. Sasser. The plan is very specific, as it must be. There are very rigid guidelines under medicare and medicaid and most private insurance companies. All these payors want to know on the front end not only the number of visits that you plan to provide but your goals, actually when you plan on discharging. Sometimes that is difficult to project, but that is part of the plan of treatment.

Chairman SASSER. In other words——

Ms. SASSER. The agency cannot change the number of visits without another physician's order.

Chairman SASSER [continuing]. In other words, the agency—a physician will specify that the home health care agency can visit a patient, for example, let us say 15 times. Then at the expiration of that 15-term visit, if the home health care agency finds that the patient still needs visits, does the home health care agency then go back to the physician and say, we need additional visits?

Ms. SASSER. Normally the original plan of treatment is for a 60-day period.

Chairman SASSER. Right.

Ms. SASSER. That plan of treatment will normally say, visit two to three times a week. The agency is responsible for getting a re-certification from that physician after the end of 60 days. They are also responsible for letting that physician know any time during that 60 days of a change in the patient's condition or if any other services are needed.

So there is a constant communication between the home health agency and the physician's office, which to be quite honest is very frustrating for the physician because he does not receive reimbursement for any of these phone calls or paperwork that the agencies send him.

Chairman SASSER. So the physician does not then see the patient again before reauthorizing the additional visits?

Ms. SASSER. Not in all cases, no.

Chairman SASSER. And he receives no reimbursement for doing the forms, he or she doesn't——

Ms. SASSER. Right.

Chairman SASSER [continuing]. So there would be a tendency, it appears to me, for the physician who is busy anyway, receiving no reimbursement for his time in dealing with the home health agency, to try to slough this off and perhaps the nurse or someone or the stenographer in the office would simply say well yes, if they need another 15 visits, so be it.

Ms. SASSER. The physician—a lot of the physician community would prefer to allow their nurse to handle that, but under very strict laws and rules, we must have the physician's signature and date. If we do not, we cannot provide services.

Chairman SASSER. But the point I am making, I suppose, is the physician is not required to see the patient again.

Ms. SASSER. No; the physician is not required under any law to see the patient.

Chairman SASSER. Right.

Ms. SASSER. He is required to say that that patient is homebound and is in need of home health services, so at any time that he questions that, he should have the patient return to his office.

Chairman SASSER. Well now you heard Mr. Cottos' suggestion that we ought to make the plan of care a more formal document. I think he said that's similar to the certificate of medical necessity that is required for other medicare services. Some propose also that the physician submitting a plan of care should be the patient's treating physician.

Do you agree that doctors now are not required to see in all cases the home health care patient that they prescribe for?

Ms. SASSER. I don't agree with that, because how could they determine whether or not home health services were needed if they had no knowledge base about the patient? They may not see them immediately before referring to home health, but they do have a history on that patient and should, if they have any question about it, call the patient in before they order services.

Chairman SASSER. Well maybe they should, but under current law doctors are not even required to see the home health care pa-

tients they prescribe for. Now that is not the fault of the Home Health Care Association, but under the present law, doctors are not required to see the home health care patients they prescribe for.

Frankly, I find that to be a little shocking, that a physician could prescribe home health care and bind medicare or medicaid, particular medicare, without having seen that patient.

Ms. SASSER. Well, the physician is responsible, however, for determining that home health services are needed, so if he doesn't see that patient, how is he going to make that determination?

Chairman SASSER. Well see, that is the question I am asking.

Ms. SASSER. Yes.

Chairman SASSER. If he or she doesn't see that patient, how do they know whether or not that patient needs home health services, or more importantly, how do they know the extent or the magnitude of the home health care services that must be rendered?

Well, those are questions, Ms. Sasser, that you or the Home Health Care Association ought not to be called upon to answer. I mean, those are clearly questions of policymakers and those who make the policy and the Health Care Financing Administration. They ought to be called upon to answer them.

Ms. Sasser, I thank you for appearing here this morning.

I anticipate holding the record open on this hearing for an additional 14 days to take any comments or statements that interested parties might wish to make, and also to perhaps promulgate some additional questions to these two witnesses and others.

Let me conclude by saying that the dialogue that we have had today with these witnesses is a necessary part of maintaining the integrity and efficiency of the health care programs of this country.

Clearly, we have a very, very serious problem with health care and its cost here in this country. I know of no one who disagrees with that, whether they be in the business of providing health care or whether they be in the business of being health care consumers.

As we see from this chart,[1] care costs in the United States are simply exploding, going up much faster than any of the other industrialized countries in the world. We selected just four countries here, Canada, Germany, Japan, and the United Kingdom. We could have put France, we could have put Italy, we could have put Belgium, almost any of the industrialized countries in the world and you would find that our health care costs here are going up at a much faster rate.

Equally alarming, we find that the growth in the so-called mandatory or entitlement programs in the Federal government are driven primarily by health care costs. Eighty-five percent of the project growth in entitlement programs in the Federal budget over the next 5 years will be driven by increases in medicare and medicaid costs alone.

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[1] See p. 6.

We are not going to be able to get a handle, in my judgment, on our problems with the Federal budget until we can get some kind of handle or come to some kind of solution on the problems of exploding health care costs.

Presently, the health care costs consume 12 percent of the gross national product of the United States, much larger than any other industrialized country. At the present rate of growth, by the end of this century, by the end of the 1900s, 20 percent of the gross national product of the United States will be devoted exclusively to health care costs.

We are finding that our products internationally are becoming uncompetitive because they must bear the cost of health care in their manufacturing. We have automobile manufacturers appearing before the Senate Budget Committee testifying that there is anywhere from $250 to $450 in health care costs in every automobile that rolls off their assembly line. As a result of that, they have difficulty in competing with automobiles manufactured in other countries.

This gives an incentive for American automobile manufacturers to move offshore, go to Mexico, to other areas to assemble and manufacture automobiles, putting American workers out of work. We see that being duplicated in industry after industry, partially driven by health care costs here in this country.

So clearly, we have to do something about getting a handle on the cost, and we have got to also find a means of expanding quality health care to literally tens of millions of Americans who cannot access it now. The tragedy of that is that of these 35 to 40 million Americans who have no health insurance, most of them are working. They are working people who have no health coverage and they are desperate.

So that is the reason for these ongoing hearings here. They are complex, this is time consuming, it is not exciting, but in the final analysis we hope to find ways to cut costs in the Federal health care system and also to learn lessons that can be translated to make the whole health care system more effective and more efficient.

Simply by holding these hearings here in Tennessee, here in Nashville, that will be reported all over this State and through the electronic media in some of the neighboring States, home health care providers who might be cutting corners, who might be padding bills—and they probably are a minority—they will know that they are being watched. This will mean, I think, that people will be more careful in the interim as we try to develop regulations or legislation to make the home health care business more cost effective and cost efficient for beneficiaries and for providers also.

I thank the witnesses for their attendance here today and for their testimony, and I thank all interested parties for their attendance also.

These hearings are adjourned.

[Whereupon, at 11:30 a.m., the committee was adjourned.]

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